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 14, 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 **July 18, 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 _____	C 07/18/2018

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

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F 000	INITIAL COMMENTS An unannounced on site investigation of a self report and an anonymous complaint was conducted by the Division of License and Protection on 7/18/18. The findings include the following:	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff/resident interviews, the facility failed to ensure that 1 applicable resident was free from non-consensual sexual contact, (Resident #2),. The findings include the following: Per medical record review, Resident #1 was admitted in 2013, with diagnoses to include, but not limited to Sexual Dysfunction, Dementia, Major Depression, Post Traumatic Stress Disorder (PTSD) and Alcohol Dependency in remission.	F 600	Corrective Action: Resident #1 was immediately placed on 1:1 supervision following the alleged incident. He was then evaluated and a physician order was received to transfer him to an acute care facility for further evaluation. Upon his return to the facility all recommendations will be reviewed and implemented as appropriate. Identify Others: All residents could be affected by this practice. Systemic Change: (1) All staff will re-educated on the facilty's policy for Abuse Prevention and Detection. A complete review of resident #1's care plan has been completed and the facility has ensured that all psychiatric recommnedations have been reviewed with his attending physician and the care plan been updated accordingly. (2) 3 Resident interviews will be conducted weekly for 12 weeks to ensure all education/interventions/measures have been effective for the prevention of abuse, neglect, misappropriation, of resident property and exploitation. Monitoring: The Administrator and Director of Nursing will review all resident interviews and appropriate actions will be implemented where necessary. Additionally, the interviews will be reviewed by the facility's QA committee. Completion Date: 9/11/18 Responsible Party: Administrator F600 POC accepted 8/13/18 MBertrandRN/PMA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 8/10/18

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.

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F 600	Continued From page 1	F 600		

Progress notes identify that the resident has had times when sexual comments have been directed toward care givers, but none towards other residents prior to the 7/9/18 incident. Interviews conducted by the State Surveyor on 7/18/18, identified that the resident rarely left his/her room, has an unsteady gait and is usually spends the day partially dressed.

In the month of May 2018 documentation identifies (8) eight occurrences of sexual comments towards staff and on one occasion hit a nurse aide during personal care. The resident was found on 3 occasions in the hall with the lower half of his/her body naked. Staff redirected the resident to his/her room without incident. Medication adjustment was made at the end of the month. In June there were (3) three documented instances when Resident #1 made inappropriate sexual comments to the nursing staff. In July (1) one incident of non-consensual sexual contact towards Resident #2.

Per review of intake form, facility internal investigation, Med Options Assessment and Advanced Practice Registered Nurse (APRN) assessment all dated 7/9/18, identify that at approximately 7 AM, Resident #1 entered Resident #2's room, partially dressed and proceeded to fondle his/her breast(s). The perpetrator pulled the victim's sheet and blanket down to his/her feet/ankles, uncovering the resident and proceeded to attempt to remove the attached brief. During this deliberate action, Resident #1 voiced various suggestive sexual comments. The victim was unable to utilize the call bell for it was attached to the blankets/sheets that had been removed by Resident #1.

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F 600	Continued From page 2 Therefore, Resident #2, began to yell for help. The victim attempted to protect her/himself by demanding the perpetrator to leave the room. The victim pulled at Resident #1's, eyeglasses and beard. Resident #1 left the room and the victim was able to use the call light to request assistance. Per internal investigation and interviews conducted by the State Surveyor on 7/18/18 with Resident #2, RN, LNA, Social Services (SS) and Administration all confirm the occurrence as documented.	F 600		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657	Corrective Action: For Resident#1, all recommendations by Med Options have been reviewed and and the care plan was updated accordingly. Identify Others: All residents have the potential to be affected by the same practice. Systemic Change: All nurses will be re-educated on the requirement to of the development, implementation and update of comprehensive care plans when behavioral recommendations are recieved from Med Options. Monitoring: All Med Option recommendations will be reviewed by the Administrator and Director of Nursing weekly for 12 weeks. An audit of those resident care plans will be completed to ensure all recommendations have been reviewed with the attedning physician and the resident's care plan has been updated accordingly. All audits will also be reviewed by the facility's QA Committee. Completion Date: 9/11/18 Responsible Party: Administrator F657 POC accepted 8/13/18 MBertrand RN/PMC	

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F 657	Continued From page 3	F 657		

or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to revise the Interdisciplinary Comprehensive Care Plan for 1 applicable resident reviewed, (Resident #1). The findings include the following:

Per medical record review, Resident #1 was admitted in 2013 with diagnoses to include, but not limited to Sexual Dysfunction, Dementia, Major Depression, Post Traumatic Stress Disorder (PTSD) and Alcohol Dependency in remission.

Per Medication Management Assessment (Med Options) dated 5/20/18 and 5/29/18, completed by the Nurse Practitioner (NP), identifies target behaviors of changes in mood, Paranoia/Delusions and changes in appetite. The NP recommends a behavior health plan for hypersexual behavior as follows: 1) Give him/her something to do with hands such as holding a blanket or stuffed animal, this will decrease the need for inappropriate touching; 2) Use diversion techniques such as turning on the TV/music (this will disrupt thinking); 3) If possibly create physical space; 4) Maintain eye contact and tell the resident the behavior will not be tolerated.

Interdisciplinary Comprehensive Care Plan identifies that the resident has little or no activity involvement. Initiatives include that the resident prefers following television, hunting, baseball and

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F 657	Continued From page 4 fishing. The plan also identifies inappropriate sexual behavior with an initiative to identify inappropriate unacceptable behavior to the resident and to monitor behaviors to determine cause. The plan as identified by Med Options, is not specifically documented in the plan of care as recommended. The facility Administrator confirmed on 7/18/18, that the plan did address the resident's interests. The administrator also confirmed that the plan was not written exactly as the NP recommended, nor did the care plan identify the alarmed Stop sign or the barrier that was across the doorway. Per observation and interview on 7/18/18, with the nursing staff, Resident #1, has a barrier on the entrance of his/her private room that identifies "Stop" and is alarmed to alert staff of unwanted visitors that could have entered the room or that Resident #1 could have exited the room. Staff confirm that the resident spends most of his/her day in his/her room, is usually not fully dressed and on three (3) occasions in May the resident was found in the hall with no pants on. S/He was redirected by the staff. None of this information is included on the Interdisciplinary Care Plan.	F 657		
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 record review and confirmed by staff interview, the facility failed to ensure that services	F 658	Corrective Action: For resident #1, a Behavior Monitoring Flow Sheet is currently in place. The nurses will receive education regarding the requirement to document behaviors, interventions utilized and outcomes as per the resident specific Medication Administration Record. Identify Others: All other residents with a Behavioral Flow Sheet in place have the potential to be effected.	

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F 658	Continued From page 5 provided meet professional standards regarding documentation of behaviors identified on the Medication Administration Record for 1 applicable resident, (Resident #1). The findings include the following: Per medical record review, Resident #1 was admitted in 2013, with diagnosis to include, but not limited to Sexual Dysfunction, Dementia, Major Depression, Post Traumatic Stress Disorder (PTSD) and Alcohol Dependency in remission. Per review of the Medication Administration Records (MAR) for the months of May/June/July 2018, it directs the nurse to document behaviors, interventions utilized and outcomes every shift. The following behavior interventions; 1). 1:1. 2) Redirect behavior; 3) toilet; 4) provide snack and outcomes are to be documented as improved, worsened or no change. The MAR identifies that behaviors are checked as reviewed for each shift, but there is no identification if targeted behaviors were present, what interventions were used and what results were obtained if any. Per review of the progress notes dated May/June/July 2018, documentation evidences the following: -May - (8) eight occurrences when the resident made sexual inappropriate comments to the nursing staff and on (1) one occasion hit the nurse aide during personal care; -June - (3) three occurrences when the resident made sexual inappropriate comments to the nursing staff; -July - (1) one incident of non-consensual sexual contact of a resident.	F 658	Systemic Change: All nurses will be re-educated on the policy and procedure for behavior monitoring. Monitoring: 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. Date of Completion: 9/11/18 Responsible Party: Administrator F658 POC accepted 8/13/18 MBeatrau RN/PMA	

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F 658	Continued From page 6 Confirmation was made by the Registered Nurse on 7/18/18 at approximately 11 AM that the nurses document on the MAR identifying that behaviors are monitored. This is evidenced by a check mark. If behaviors are identified, the nurse will further document in the progress notes. However, the documentation in the progress notes does not follow the direction identified on the MAR consistently, as it relates to behaviors, interventions applied and outcomes obtained. (Lippincott Manual of Nursing Practice (9th ed.) Wolters Kluwer Health/Lippincott Williams & Wilkins.)	F 658		