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

June 25, 2021

Mr. Timothy Urich, Administrator The Pines At Rutland Center For Nursing And Rehab 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 1, 2021.** 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

Pamila MCotaRN



Center for Nursing & Rehabilitation

June 24, 2021

Pamela Cota

Licensing Chief

Division of Licensing and Protection

Dear Pam,

Please see the attached Plan of Correction for the unannounced on-site complaint investigation completed at The Pines at Rutland on June 1, 2021.

I trust that we have provided all necessary information however; should you have any questions, please do not hesitate to contact us.

Tim Urich.

Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/14/2021 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			ON	MB NO.	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
475018			B. WING			C 06/01/2021	
NAME OF P	ROVIDER OR SUPPLIER	201		ST	TREET 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)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	:	(X5) COMPLETION DATE
F 000	An unannounced on	site investigation was	F	000			-
F9999	no federal regulatory State regulatory viola FINAL OBSERVATIO The following violatio Operation Rules for N identified regarding fa dealth due to a fall. 2.9 Reports to the Lic The following reports licensing agency: a. At any time a fire or regardless of the size agency and the Depa must be notified by the written report must be departments by the r the report shall be kee b. Any untimely deatt an untoward event, s results in hospitalizat of restraint, etc., shal agency by the next b written report that de event. c. Any unexplained of of a resident for a pe shall be reported pro	Division of Licensing and Protection. There were no federal regulatory deficiencies. The following State regulatory violation was identified: FINAL OBSERVATIONS The following violation of Vermont Licensing and Operation Rules for Nursing Homes was dentified regarding failure to report an untimely dealth due to a fall. 2.9 Reports to the Licensing Agency The following reports must be filed with the licensing agency: a. At any time a fire occurs in the facility, 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		9999	Corrective Action: The resident in question is deceased therefore corrective action can be implemented. Identify Others: All residents and patients may be affected by the practice, therefore the systemic change applies all patients and residents. Systemic Change: The facility will incorporate the review of all Incand Accident reports into the facility's Daily Clir Review meeting for the prupose of timely ident of incidents that require report to the regulatory Additionally, the IDT will review the 24-hour preport in the EMR for the same purpose. Any that meets the appropriate criteria for reporting investigated and reported to the regualtory bod within the appropriate timeframe. Monitoring: A log of all Incident and Accident Reports will the for 3 months to ensure compliance. The log wereviewed monthly by the facility's Quality Assur Committee to ensure compliance. Responsible Party: Administrator Date of Completion: 7/5/2021 TAG F9999 POC approved 6/24/21 G. Mercure/S. Leavitt	this is to cident nical tification y body. ogress incident will be dy	YGI DATE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1XAK11

Facility ID: 475018

ADMINISTRATOR

PRINTED: 06/14/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING __ С 475018 B. WING 06/01/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

IE PINES	S 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) COMPLETIC DATE		
F9999	Continued From page 1	F9999				
	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.					
	This requirement was NOT MET, as evidenced by:					
	Based on record review and staff interview, the facility failed to report an untimely death after a fall with major injury and hospitalization of a resident.					
	Findings include the following:					
	Per record review, Resident # 3 had a fall with major injury on 05/04/21 at approximately 1700. This resident was sent to the emergency room and was hospitalized due to vertebral (spinal) and pelvic fractures. The resident also sustained a laceration to the head. S/he was discharged back to The Pines at Rutland Center for Nursing & Rehabilitation on 05/06/21. This resident was placed on comfort care and died four days later on 05/10/21.		32			
	A nurse note (05/04/21 - 16:04) indicated that the resident was feeling "woozy" on the 11-7 shift. An assessment was conducted by the nurse. The resident was reminded to use the call light for assistance to get up. The nurse practitioner was notified. The nurse practitioner assessed the resident. The practitioners note (05/04/21) indicates the "patient presents for dizziness and	Control of the Contro				

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

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	*1	475018	B. WNG			06/0	1/2021
NAME OF PROVIDER OR SUPPLIER THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI				STREET ADDRESS, CITY, STATE 99 ALLEN STREET RUTLAND, VT 05701	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F9999	[s/he] was going to fa were to seek respirat work, orthostatic bloo nebulizer treatment a fell an hour later. Per interview on 06/0 administrator confirm	norning. The patient thought II." New physician orders ory therapy evaluation, lab d pressure readings and s needed. The resident then	F99	999			