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 18, 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 **July 14, 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

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 _____	07/14/2021

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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E 000	Initial Comments A review of Emergency Preparedness requirements was conducted by the Division of Licensing and Protection on 7/14/21, during the recertification survey. The facility is in substantial compliance with the Emergency Preparedness requirements.	E 000		
F 000	INITIAL COMMENTS An unannounced on-site recertification survey was conducted in conjunction with a complaint investigation at The Pines at Rutland center by the Division of Licensing and Protection on 7/12-7/14/21. There were regulatory violations identified.	F 000		
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 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).	F 656	Corrective Action: A communication book has been implemented for Resident #121 that will be utilized between the skilled nursing facility and the dialysis center. Resident #121's care plan has been modified to include the use of the communication book. Identify Others: All residents and patients that receive outpatient dialysis treatment would be at risk for this same practice. Systemic Change: All patients/residents with orders for outpatient dialysis treatment will have a communication book implemented immediately. This will be outlined in their respective comprehensive care plan. Monitoring: A weekly audit of all residents/patients with dialysis treatment will be conducted to ensure communication book is in place and being utilized. Audit will also ensure that the resident/patient's care plan indicates use of communication book. The weekly audits will be conducted for a period of three months and submitted to the facility's Quality Assurance Committee for review. The need for further auditing beyond the three months will be determined by the committee. Responsible Party: Director of Nursing Completion Date: 9/7/2021	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	8/6/2021

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 656	Continued From page 1 (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 upon interview and record review, the facility failed to ensure that Interventions for 1 of 2 residents [Res. #121] who require dialysis were implemented per the resident's Care Plan. Findings include: Review of the medical record for Res. #121 reveals the resident was re-admitted to the facility on 6/25/21 with diagnoses that include End Stage Renal Disease, Anemia in Chronic Kidney Disease, and Dependence on Renal Dialysis. Per review of Physician Orders for Res.#121, the resident is scheduled for dialysis treatments on Tuesdays, Thursdays, and Saturdays. Review of Res.#121's Care Plan dated 6/25/21 reveals the resident is identified as 'needs dialysis related to renal failure' with interventions that	F 656	**TAG F 656 POC Accepted on 8/17/21 by T. Dougherty/P. Cota**	

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F 656	Continued From page 2 include 'Send communication forms/book with resident to dialysis and adjust plan of care as needed on return'. An interview was conducted with the acting Unit Manager [UM] on Res.#121's unit on 7/13/21 at 3:25 PM. The UM stated that regarding Res.#121 there was no documentation method used to share information between the dialysis center and the long term care facility regarding the resident's condition before, during, or after dialysis treatments. The UM stated If there is a question regarding the resident, it would be communicated by phone. Review of Res.#121's medical record revealed no documentation of any communication between the facility and the dialysis center before or after any dialysis treatments. An interview was conducted with Res.#121 on 07/14/21 at 9:35 AM. The resident stated there is no communication book that h/she is given or carries to dialysis appointments. The resident stated that h/she had undergone a dialysis treatment the day before. During the interview, the Unit Manager entered the room and asked if the resident was given any binder or folder while at dialysis and resident stated no. Per interview with the Director of Nursing [DON] on 7/14/21 at 1:25 PM, the DON stated that there was no facility policy regarding residents receiving dialysis, no written set communication process or who was responsible for communicating, and no procedure stating where communication and responses would be documented in the medical record.	F 656		
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698	Corrective Action: A communication book has been implemented for Resident #121 that will be utilized between the	

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F 698	Continued From page 3 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure that 1 of 2 residents who require dialysis [Res. #121] received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Findings include: Review of the medical record for Res. #121 reveals the resident was re-admitted to the facility on 6/25/21 with diagnoses that include End Stage Renal Disease, Anemia in Chronic Kidney Disease, and Dependence on Renal Dialysis. Per review of Physician Orders for Res.#121, the resident is scheduled for dialysis treatments on Tuesdays, Thursdays, and Saturdays. Review of the Centers for Medicare and Medicaid Services interpretive guidance for regulations regarding residents receiving dialysis include: "It is essential that a communication process be established between the nursing home and the dialysis facility to be used 24-hours a day. The care of the resident receiving dialysis services must reflect ongoing communication, coordination and collaboration between the nursing home and the dialysis staff. The communication process should include how the communication will occur, who is responsible for communicating, and where the communication and responses will be	F 698	Continued from page 3 skilled nursing facility and the dialysis center. Resident #121's care plan has also been modified to include the use of the communication book. Additionally, the use of the communication book has been added to this resident's Medication Administration Record to ensure the book is utilized on those days the resident receives dialysis treatment. Identify Others: All residents/patients receiving outpatient dialysis treatment would be at risk for this same practice. Systemic Change: All residents/patients with orders for outpatient dialysis treatment will have a communication book implemented immediately upon orders being received. The use of the communication book will be added to the resident/patient's respective Medication Administration Record to ensure that the book accompanies them to and from the dialysis center. Monitoring: A weekly audit of all residents/patients receiving outpatient dialysis treatment will be conducted to ensure communication book is in place and being utilized. The weekly audit will be conducted for a period of three months and submitted to the facility's Quality Assurance Committee for review. The need for auditing beyond the three months will be determined by the committee. Responsible Party: Director of Nursing Date of Completion: 9/7/2021 **TAG F 698 POC Accepted on 8/17/21 by T. Dougherty/P. Cota**	

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F 698	Continued From page 4 documented in the medical record ...' An interview was conducting with the acting Unit Manager [UM] on Res.#121's unit on 7/13/21 at 3:25 PM stated that regarding Res.#121 there was no documentation method used to share information between the dialysis center and the long term care facility regarding the resident's condition before, during, or after dialysis treatments. The UM stated If there is a question regarding the resident, it would be communicated by phone. Review of Res.#121's medical record revealed no documentation of any communication between the facility and the dialysis center before or after any dialysis treatments. Per the Clinical Journal of the American Society of Nephrology's Patient and Facility Safety in Hemodialysis: Opportunities and Strategies to Develop a Culture of Safety (nih.gov) "Care transitions between providers and care settings provide prime opportunities for communication errors. These transitions are common among dialysis patients as they undergo access procedures, hospitalizations, and specialist consultations. Facilities should evaluate scripted communication guides so that vital data are readily available and shared with providers. Patients should have copies of their problem's lists, medications, allergies, and other vital information. These should be updated frequently, and patients should be educated to share copies with providers." Review of Res.#121's Care Plan dated 6/25/21 reveals the resident is identified as 'needs dialysis related to renal failure' with interventions that include 'Send communication forms/book with resident to dialysis and adjust plan of care as	F 698		

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F 698	Continued From page 5 needed on return'. An interview was conducted with Res.#121 on 07/14/21 at 9:35 AM. The resident stated there is no communication book that h/she is given or carries to dialysis appointments. The resident stated that h/she had undergone a dialysis treatment the day before. During the interview, the Unit Manager entered the room and asked if the resident was given any binder or folder while at dialysis and resident stated no. Per interview with the Director of Nursing [DON] on 7/14/21 at 1:25 PM, the DON stated that there was no facility policy regarding residents receiving dialysis, no written set communication process or who was responsible for communicating, and no procedure stating where communication and responses would be documented in the medical record.	F 698		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— §483.45(e)(1) Residents who have not used	F 758	Corrective Action: For Resident #14, the PRN medication order was modified to include a 14-day stop date. Identify Others: All residents that have an order for PRN antipsychotic medications could be at risk for the same practice. Systemic Change: The orders for all residents that have been prescribed PRN psychotropic medications will be reviewed to ensure that there is a 14-day stop date in place. Education will be provided to all Licensed Nurses and Practitioners regarding the requirement for a 14-day limit on PRN pschotropic medications. Monitoring: A weekly audit of all PRN pschotropic medications will be conducted to ensure that each order has a 14-day limit. These audits will be conducted for a period of three months and will be reviewed by the facility's Quality Assurance Committee. The need for further auditing beyond the three months will be determined by the committee. Responsible Party: Director of Nursing Completion Date: 9/7/2021	

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F 758	Continued From page 6 psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure 1 applicable resident (Resident # 14) was free from unnecessary medications. Findings include: Per review of the clinical record, Resident # 14	F 758	**TAG F 758 POC Accepted on 8/17/21 by T. Dougherty/P. Cota**	

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F 758	Continued From page 7 has a PRN (as needed) order for Seroquel (an antipsychotic medication). The order was written on 5/20/21 with no stop date. Regulation requires that antipsychotic medications must have a 14 day stop date and be re-evaluated by the provider without exception. Review of the Medication Administration Records (MAR) for May - July 2021 shows that the resident received the PRN Seroquel on 7 occasions. This was confirmed by the Director of Nursing and the Administrator on 7/14/21 at 12:49 PM.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761	Corrective Action: (1) All expired supplies and medications identified during the survey were immediately discarded. (2) All refrigerators identified during survey to be lacking recorded temperatures have been inspected to ensure proper temperatures. A daily temperature log has been implemented and temperatures will be recorded daily. Identify Others: (1) All drugs and biologicals must be labeled in accordance with currently acceptable professional principles. (2) All drugs and biologicals must be stored under proper temperature controls. Systemic Change: (1) Education to be completed with all licensed nurses regarding the need to appropriate label all drugs and biologicals. (2) Education to be completed with all licensed nurses regarding the need to maintain drugs and biologicals under proper temperatures Montioring: (1) A weekly audit of all nuring medication carts will be completed to ensure there are no expired drugs or biologicals. The audit will also ensure all Lantus has an opened date. (2) A weekly audit will be conducted of all medication refrigerators to ensure that temperatures are being checked daily and recorded. These audits will be conducted for a period of three months and the results will be reviewed monthly by the facility's Quality Assurance Committee. The need for auditing beyond the three months will be determined by the committee. Responsible Party: Director of Nursing Completion Date: 9/7/2021	

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F 761	Continued From page 8 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to ensure that medications were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Findings include: On 7/14/2021 the following observations were noted: 2nd floor - 1 red-top Vacuette expired on 7/7/21. Medication refrigerator temperatures were not recorded between 7/1/21 - 7/11/21. This was confirmed by unit nurse at 9:55 AM. 3rd floor - 1 red-top Vacuette expired on 7/7/21; 11 blue-top Vacuettes expired on 3/6/2; 1 bottle of Thera med vitamins expired on 5/21. This was confirmed by unit nurse at 10:18 AM. 4th floor - 2 red-top Vacuettes expired on 7/7/21 - confirmed by unit nurse at 10:15 AM. Per Observation on 7/14/21 of the Medication Carts on each unit the follow observations were made: 2nd floor north - 1:10 PM - Lantus 100 units/ml (milliliter) with no opened date 4th floor south -1:24 PM - Lantus 100 units/ml with no opened date. Both observations confirmed by the respective Unit nurses at time of observations. Facility policy is to discard 28 days after opening. Both residents confirmed by Unit Nurses as residing at the facility as of 7/14/21.	F 761	**TAG F 761 POC Accepted on 8/17/21 by T. Dougherty/P. Cota**	

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