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

November 9, 2018

Ms. Melissa Greenfield, Administrator
Rutland Healthcare And Rehabilitation Center
46 Nichols Street
Rutland, VT 05701-3275

Dear Ms. Greenfield:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 17, 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
	475039	A. BUILDING _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUTLAND HEALTHCARE AND REHABILITATION CENTER	46 NICHOLS 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 An unannounced onsite Emergency Preparedness review was completed by the Division of Licensing and Protection from 10/15/18- 10/17/18. The facility was found in substantial compliance with regulations related to Emergency Preparedness.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite re-certification survey was completed by the Division of Licensing and Protection from 10/15/18 -10/17/18. The findings include the following:	F 000		
F 658 SS=D	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 interview and record review the facility failed to meet professional standards of quality for 1 of 22 residents in the applicable sample (Resident #180) regarding having physician orders for treatment. Findings include: Per record review Resident #180 was admitted to the facility on 10/11/18 with bilateral nephrostomy tubes (plastic tubes that are placed through the skin of the lower back into the kidneys) and a gastrostomy tube (tube inserted through the abdomen that delivers nutrition directly to the stomach). There was no evidence in the medical record that physician's orders were written regarding how to care for and maintain both of	F 658	1. Resident #180 orders have been written on how to care for and maintain both the nephrostomy tubes and the gastrostomy tube. 2. Residents residing in the facility that have nephrostomy and gastrostomy tubes have the potential to be affected by the alleged deficient practice. 3. Education provided to the nursing staff regarding policy and procedure on how to care for and maintain both the nephrostomy tubes and the gastrostomy tube. 4. Audits will be conducted weekly x1 month then monthly x3 months by DNS or designee to monitor effectiveness of the plan. 5. Results of the audit will be reported to the QAPI committee X3 months at which time the committee will determine further frequency of the audits. F-658 POC accepted 11/8/18 M. Bertrand RN/S. Levy, RN	11/12/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Greenwood | TITLE: Administrator | (X6) DATE: 11/8/2018

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 658	Continued From page 1 the nephrostomy tubes and the gastrostomy tube. Per interview on 10/17/18 at 1:47 PM with the Unit Manager, s/he confirmed that there were no physician's orders written for the care and maintenance for both of the nephrostomy tubes and the gastrostomy tube. Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins, pg 17	F 658		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to ensure that the environment was free from accident hazards for at least 3 of 22 residents in the applicable sample (Residents #42, Resident #23, and Resident #51). Findings include: Per observation on 10/15/2018 at 4:13 PM, an exposed heating pipe located in an unlocked bathroom on 3 North, registered 217 degrees Fahrenheit (F.) on a laser radiation thermometer. Per interview with the Unit Manager and a Licensed Nurse Aide (LNA), both indicated that	F 689	1. None of the residents residing in the facility had negative effects as a result of the alleged deficient practice. 2. The exposed heating pipe located in the bathroom on 3 north has been fixed with proper insulation. 3. Residents residing in the facilty that are independent have the potential to be affected by the alleged deficient practice. 4. Education provided to the maintenance department regarding potential burn hazards and that first degree burns can occur if temperatures are above 140 degrees fahrenheit. 5. Environmental/safety rounds will be conducted by CED and maintenance weekly x4 weeks and then monthly x3 months. 6. Results of the audit will be reported to the QAPI committe x3 months at which time the committee will determine further frequency of the audits. F-689 POC accepted 11/8/18 M. Bertrand RN/S. Berry, RN	10/17/18

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F 689	Continued From page 2	F 689		

residents do not use this bathroom unassisted. On 10/15/2018, Resident #42 was observed entering the bathroom unassisted, to use the toilet. Per observation during the three days of survey, Resident #23 was seen propelling about the facility in a wheel chair unattended. Resident #51, was observed during the survey wandering about the facility independently with a walker.

On 10/16/2018, at 8:15 AM, the temperature of the pipe registered 177 degrees F. During an interview with the Administrator and Maintenance Director, on 10/16/2018, at 8:20 AM, the pipe registered a temperature of 144-145 degrees F. The Maintenance Director confirmed that they were not aware that the pipe was not protected by insulation. Both Administrator and Maintenance Director confirmed that the temperature of the pipe was too hot.

Per the State of Michigan, Department of Licensing and Regulatory Affairs, Burn Hazards Related to Heated Surfaces in Long Term Care Facilities, the document states "The facility must ensure that (1) the resident environment remains free of accident hazards as is possible; and (2) each resident receives adequate supervision and assistance devices to prevent accidents,"..."The 140 degrees F. temperature corresponds to 60 degrees C. At this temperature a first degree burn will occur in approximately 3 seconds. This temperature corresponds to the threshold between maximum pain and numbness, as well as the threshold between reversible injury and possible irreversible injury".

F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760	1. Resident #48 had no negative effects as a result of the alleged deficient practice and the physician has been updated.	11/12/18

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F 760	Continued From page 3	F 760		

The facility must ensure that its-
§483.45(f)(2) Residents are free of any significant medication errors.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and confirmed by staff interview, the facility failed to ensure 1 of 22 residents was free from significant medication errors (Resident #48). The findings include the following:

Per medical record review, Resident #48 has a physician order dated 10/9/18, directing staff to check blood sugars, before meals and at bedtime. The order also directs staff to administer Novolog Insulin 16 units subcutaneous (sc) with lunch and supper. Per observation on 10/15/18 at 1:45 PM, the License Practical Nurse (LPN) administered injectable insulin into the residents upper left arm. The LPN was questioned by the surveyor, why the resident was given insulin at that time. The LPN explained, Resident #48 had a blood sugar of 80 before lunch. The nurse determined the blood sugar was low and held the insulin and instructed the resident to eat his/her noon meal. At 1:45 PM the LPN rechecked the blood sugar that registered 157, s/he then administered the noon dose of insulin and documented the administration as given at 11:30 AM. The surveyor reviewed the physician orders and the inaccurate documentation of the Insulin in the medication administration record, with the LPN and the Unit Manager on 10/15/18 at approximately 3:30 PM. Both nurses confirm that the physician's orders were not followed, that the insulin should not have been administered at 1:45 PM and the LPN did not document the time of the administration regarding the physcian orders not being followed.

2. Residents residing in the facility with current medication orders have the potential to be affected by the alleged deficient practice.
3. Education provided to the licensed nurses regarding policy for medication administration.
4. Insulin adminstration observation audits will be conducted weekly x1 month then monthly x3 months by DNS or designee to monitor effectiveness of the plan.
5. Results of the audit will be reported to the QAPI committee x3 months at which time the committee will determine further frequency of the audit.

F-760 POC accepted 11/8/18
M. Bertrand RN/S. Perry LPN

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F 760	Continued From page 4 accurately.	F 760		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to store, distribute and serve food in accordance with professional standards for food service safety. Findings include: 1. During a tour of the kitchen on 10/15/18 at 9:38 AM, there was a fan mounted to the wall that was located to the left of a counter used for cutting meat and preparing other foods. The fan had a coating of grease and dust on the outer metal covering with the potential to contaminate the food preparation area. This fan also had the	F 812	1. None of the residents residing in the facility had negative effects as a result of the alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. The fan mounted to the wall located to the left of a counter used for cutting meat and preparing food has been removed. 4. Convection ovens and the table located next to the steam table have been cleaned. 5. Education provided to the dietary staff regarding policy and procedure on cleaning standards. 6. Education provided to the dietary staff regarding policy and procedure on checking the sanitizer in the sinks. 7. Education provided to the dietary staff regarding policy and procedure on monitoring food temperatures. 8. Cleaning, temp log and sanitizer log Audits will be conducted weekly x1 month then monthly x3 months by DNS or designee to monitor the effectiveness of the plan. 9. Results of the audit will be reported to the QAPI committee X3 months at which time the committee will determine further frequency of the audits. F-812 POC accepted 11/8/18 M. Bertrand RN / S. Perry RN	11/12/18

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F 812	Continued From page 5 potential to blow dirt and grime onto clean mugs that were stored on a table to the left of the fan. The kitchen had a unit that contained 2 convection ovens; and on the outside of this unit there was a build-up of grease and grime. In the center of the kitchen area, there was a table located next to the steam table that had a lower shelf which stored the pans used for the steam table. The lower shelf of this table was covered in crumbs and food particles. These observations were confirmed at the time of the tour with the Dietary Manager. 2. Per observation of the three bay sink that was used to wash pots and large kitchen items, there was no evidence that the sanitizer in the sink had been checked for efficacy since 10/1/18. Per interview on 10/15/18 at 10:06 AM with the dietary manager, s/he confirmed that the sanitizer had not been checked from 10/1/18 to 10/14/18. S/he stated that his/her dietary aide had checked the efficacy of the sanitizer on 10/15/18; however, mis-marked the date as 10/1/18. 3. Per review of the food temperature logs for breakfast, lunch, and dinner from June 1, 2018 to October 14, 2018 there were 408 opportunities to monitor the food temperatures prior to food service and 66 of those opportunities were not done. Per interview on 10/16/18 at 3:24 PM with the Dietary Manager, s/he confirmed that monitoring of the food temperatures prior to meal service was not done consistently; and should always be done prior to every meal.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842	1. Resident #54 DNR/CPR orders were clarified and updated to match the residents current colst form. 2. Resident #66 oxygen orders were	11/12/18

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F 842	Continued From page 6 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842	and changed in the treatment records to reflect current orders. 3. Resident #48 had no negative effects as a result of the alleged deficient practice and the physician has been made aware. 4. Resident #42 plan of care has been revised to reflect current code status. 5. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 6. Education provided to the licensed nursing staff regarding policy and procedure on physcian orders. 7. Education provided to the licensed nursing staff to ensure residents COLST form changes are updated in the residents plan of care to reflect residents current status. 8. Colst form Audits will be conducted weekly x1 month then monthly x3 months by DNS or designee to monitor. effectiveness of the plan. 9. Physcian order audits will be conducted weekly x1 month then monthy x3 months by DNS or designee to monitor awareness of the plan. 10. Insulin administration observation audits will be conducted weekly x1 month then monthly x3 months by DNS or designee to monitor awareness of the plan. 11. Results of the audit will be reported to to the QAPI committee x3 months at which time the committee will determine further frequency of the audits. F842 POC accepted 11/8/18 M. Bertrand RN/S. Nurse, W	

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F 842	Continued From page 7	F 842		

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to maintain medical records that were complete and accurately documented for 4 of 22 residents in the applicable sample (Resident # 54, Resident #66, Resident
#48, and Resident #42). Findings include:

1. Per record review Resident #54's Clinician's Orders for DNR (do not resuscitate)/CPR (resuscitate) and Other Life Sustaining Treatment (COLST) form from 9/9/15 read, "CPR/Attempt Resuscitation". The physician's orders for

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F 842	Continued From page 8	F 842		

10/1/18 to 10/31/18 read, "DNR/DNI (do not intubate)". Per interview on 10/17/18 at 11:15 AM with the Unit Manager, s/he confirmed that the COLST form did not match and/or reflect the physician's orders for Resident #54 for 10/1/18 to 10/31/18; and stated that the facility policy was to follow the orders from the COLST form.

2. Per observation on 10/15/18 at approximately 1:00 PM, Resident #66 was not wearing oxygen. Per interview with the resident's family member at the time, s/he stated that the resident had not been wearing oxygen for quite some time. Per review of the physician's orders dated 10/1/18 to 10/31/18 for Resident #66, the order read, "Oxygen at 1-2 L (liters) via nasal cannula to maintain oxygen levels greater than 86%". Per interview on 10/17/18 at approximately 2:15 PM with the Unit Manager, s/he confirmed that Resident #66 had not been wearing oxygen and confirmed that the orders from 10/1/18 to 10/31/18 reflect that the resident should be wearing oxygen. The surveyor received additional information from the Administrator on 10/18/18 which showed that on 6/25/18, a physician's order read, "Clarification 02(oxygen) 1-2 L via NC (nasal cannula) PRN (as needed) for SPO2 (oxygen level in the blood) less than 86%". There was no evidence in the record that Resident #66's oxygen order was changed to reflect the clarification order from 6/25/18.

3. Per observation on 10/15/18 at 1:45 PM, the License Practical Nurse (LPN) administered injectable insulin into Resident #48's upper left arm. The physician's order directed staff to administer Novolog Insulin 16 Units SC (subcutaneous) via Pen, at 11:30 AM with lunch. The Medication Administration Record (MAR)

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F 842	Continued From page 9	F 842		

identifies that the insulin was administered at 11:30 AM by the LPN. Both the MAR and the physician orders were reviewed with the Unit Manager and the LPN on 10/15/18 at approximately 3:30 PM. Both nurses confirm that the physician's orders were not followed, that the insulin should not have been administered at 1:45 PM, and the LPN did not document the time the Insulin was administration accurately.

4. Per record review, Resident # 42's current Clinician's Orders for DNR (do not resuscitate)/CPR (resuscitate) and Other Life Sustaining Treatment (COLST) form read "DNR/DNI". The Resident's care plan dated 4/26/2018, stated "Full Code" (resuscitate). Per interview on 10/16/2018 at 3:30 PM, with the Unit Manager s/he confirmed that the COLST form did not match the Resident's care plan and the care plan should have been updated when the COLST form was changed.

November 8, 2018

Pamela Cota, Licensing Chief

Division of Licensing and Protection

HC 2 South

280 State Drive

Waterbury, VT. 05671

Dear Ms. Cota:

Enclosed is the updated plan of correction requested for the deficiencies sited during the October 17, 2018 annual survey for Rutland Health and Rehab Center. This POC is our creditable allegation of compliance. Should you have any questions please call me during normal business hours.

Sincerely,

Melissa Greenfield

Melissa Greenfield, Executive Director