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

October 7, 2021

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

Dear Ms. Walker:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 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

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 _____	C 09/01/2021

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
F 000	INITIAL COMMENTS An unannounced on-site investigation of two facility reported incidents was conducted by the Division of Licensing and Protection on 9/1/2021. There was a regulatory deficiency identified as a result of the investigations.	F 000	Rutland Healthcare & Rehab provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law.	
F 600 SS=G	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 interview and record review the facility failed to ensure that one of three residents in the sample were free from physical abuse on three occasions, (Resident #2). Findings include: Per record review Resident #1 has diagnoses that include Alzheimer's disease, dementia with behavioral disturbances, wandering, and violent behavior. S/he has a history of anxiety, aggression, and being resistive to care. Resident #1's care plan reflects a risk for resident-to-resident altercation due to cognitive	F 600	**F-Tag 600**- Resident # 2 was assessed by nursing immediately and comforted by social services. Resident #1 was seen by the provider, had temporary hospital stay and medication adjustment, and the care plan was reviewed and revised Residents/patients residing in the facility have the potential to be affected by the alleged deficient practice. Resident safety is of the utmost importance to center staff. Education has been provided regarding resident supervision on the units and the importance of redirecting and interjecting between residents before behaviors escalate. Staff have been educated to call administrative staff and/or recreation to assist during busy care times to ensure appropriate supervision on units. Administrative schedules have been adjusted to accommodate care needs on the units and extra staff have been scheduled/assigned to help with meal times.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CED — (X6) DATE: 10/5/21

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.

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 _____	C 09/01/2021

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
F 600	Continued From page 1 deficit and wandering, and the potential to exhibit physical behaviors related to cognitive loss/dementia. Progress Notes indicate Resident #1 was becoming aggressive with other residents and staff who attempt to redirect her/him. 1. On 7/3/2021 at approximately 8:30 PM Resident #1 hit Resident #2 in the face, leaving a red mark on her/his cheek. A facility internal investigation of the incident states "On Saturday, July 3rd, staff witnessed [resident #1] grab another resident's walker. In effort to get [her/him] to stop touching the resident's walker, [Resident #2] grabbed [Resident #1's} arm and pushed [her/him]. [Resident #1] turned and hit [Resident #2] in the face with [her/his] hand and [Resident #2's] glasses fell off. Staff immediately separated the residents and called the nurse for assistance. A red mark was noticed on [Resident #2's] face". During an interview on 9/1/2021 at 1:30 PM a facility LNA (Licensed Nursing Assistant) #1 who witnessed the incident stated that Resident #1 had pushed Resident #2's wheelchair and then turned and hit Resident #2 in the face. Per interview on 9/1/2021 at 3:30 PM, LNA # stated that s/he had not seen Resident #1 have behavior issues often. However, the LNA was there for the incident that occurred on 7/3/21. The LNA stated s/he did not witness the event but came to the assistance of the other LNA. Resident #2 was upset but not crying and brought back to her/his room. Staff then did checks on Resident #1 throughout the rest of the shift. 2. Per record review, on 8/21/2021 Resident #1 grabbed Resident #2's arm and repeatedly hit her/him in the head. A nurse progress note	F 600	Resident behaviors, interventions and safety are discussed regularly in morning meetings, clinical huddles, Customers at Risk (CAR), TEAM and Provider huddles; this will continue. Audits on staff knowledge of supervision practices will be conducted weekly X4 and monthly X3 by CED or designee to monitor the effectiveness of the plan. Results of the audit will be reported to the QAPI committee X3 months at which time the committee will evaluate the data and act on the information as indicated. Compliance Date of 10/1/21 F600 POC accepted 10/7/21 Streeman RN/ RNC	

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 _____	C 09/01/2021

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
F 600	Continued From page 2 written on 8/21/2021 at 6:05 PM states "The LNA reported to writer and stated [Resident #1] came up behind [Resident #2] and grabbed [her/his] arm and squeezed and with [her/his] other hand proceeded to smack the victim in the back of the head hard about five times. I ran down and removed [Resident #1's] hand from [Resident #2's] arm and escorted [Resident #1] away from the victim". Per interview at on 9/1/21 at 3:48 PM, LNA #2 stated that Resident #1 "has been more agitated lately towards a few other residents. It's a day-to-day thing with his/her behavior, and there seems to be no pattern. [Resident #1] will grab other's walkers, and often grabs [Resident #2's] wheelchair. [Resident #2] gets very upset when [s/he] does this. [Resident #1] will also wander down to [Residents #2's] room and this would also upset [Resident #2]. We try to keep [Resident #1] out of others' rooms as much as possible but those behaviors kind of set off other residents too." When asked to describe the incident that took place on 8/21/2021, LNA #2 stated "I was looking down the hall and [Resident #1] came up behind [Resident #2] and grabbed [her/him] very hard and then just started hitting [her/him] on the back of the head. [S/he] did not provoke him in anyway, and as soon as I saw this, I sprinted all the way down the hall and removed [Resident #1] from the situation and got someone else to come over. [S/he] just seemed to go off and just grabbed [her/him] and then proceeded to hit [her/him] in the back of the head with [her/his] other hand. I was coming out of the laundry room from getting towels and washcloths or something and then I looked up. I think the nurse might have been behind the nurse's station. [Resident #2] seemed very quiet, a little	F 600		

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 _____	C 09/01/2021

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
F 600	Continued From page 3	F 600		

bit upset, [s/he] was stunned. [She/he] stated that [she/he] was afraid of [her/him]. There are twenty-four residents here, so you kind of just swap out kind of keeping an eye on where [s/he] is at all times making sure [s/he] isn't obviously anywhere near [Resident #2's] room".

A progress note written on 8/19/2021 at 1:28 PM regarding an interdisciplinary team meeting (CAR) states that Resident #1 "becomes easily agitated with direct 1:1 care when wandering, staff provides distant supervision". However, there were no staff providing direct supervision at the time of the incident.

3. Per record review on 8/23/21 while an LNA was attempting to redirect Resident #1 from Resident #2, Resident #2 swatted Resident #1 away. Resident #1 hit Resident #2 in the head twice and "slammed" the LNA into the wall. After this incident Resident #2 was moved to a different unit in the facility for "saftey". A social services note written on 8/24/2021 states that during an interview with Resident #2 s/he stated, "[S/He] really hit me pretty hard. I didn't do nothing to [her/him] to cause that. I would understand if I had".

During an interview with a facility LNA #1 at 1:30 PM on 9/1/21 s/he stated that s/he was not assigned to the unit at the time of the last incident that occurred on 8/24/21, but that Resident #2 was moved over to the unit that s/he was assigned to immediately after the altercation for her/his safety. The LNA stated that Resident #2 was upset and scared. LNA #2 stated that s/he had told Resident #2 that it was for her/his own protection and states Resident #2 is doing much better on this unit.

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 _____	C 09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUTLAND HEALTHCARE AND REHABILITATION CENTER	48 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
F 600	Continued From page 4 During observation of Unit Three on 9/1/2021 at 12:25 PM Resident #1 was seen in bed with his eyes closed. Staff were not visible in hallway. There were two Licensed Nursing Assistants (LNA) and an LNA in training assigned to the unit. An LNA and the LNA in training were in another resident's room towards at the other end of the hall, and the other LNA was assisting another resident with the door closed. The nurse assigned to the unit was in a residents' room which was further down hall. At 4:15 PM Resident #1 was again observed in bed with her/his eyes closed. There were no staff visible in the hallway at that time. Two activity staff members were behind the nurse's station. The two activity staff exited the nurse's station and entered the day room, the hallway is not visible from the day room, and no other visible staff were present at that time. Per interview with the Director of Nursing Services (DNS) on 9/1/21 at 4:42 PM, s/he confirms that Resident #1 has had behavioral issues and altercations with other residents on the unit. Staff have attempted one on one, but s/he does not do well with that, so they supervise her/him from a distance. However, s/he also stated they are "not always able to get to [her/him] fast enough, they just don't expect it".	F 600		