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

April 11, 2023

Ms. Amy Walker, Administrator
Rutland Healthcare & 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 **March 22, 2023.** 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

Pamela M. Cota, RN
Licensing Chief

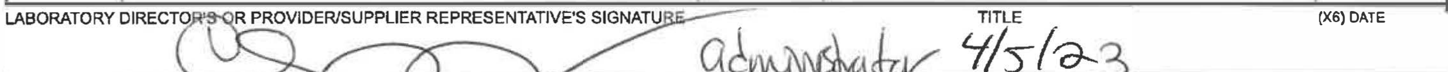
PRINTED: 04/04/2023
FORM APPROVED
OMB NO. 0938-0391

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 ______	03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUTLAND HEALTHCARE & 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 The Division of Licensing and Protection conducted an onsite, unannounced investigation of the facility's Emergency Preparedness Program on 03/22/2023. There were no regulatory findings related to this investigation.	E 000	The Rutland Health and Rehab Center 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	5/6/23
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced recertification survey and staff vaccination review from 03/20/2023 through 03/22/2023. The following regulatory deficiencies were identified:	F 000		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that residents who are trauma survivors receive trauma informed care that mitigates triggers that may re-traumatize residents for two of two residents (Resident #4 and Resident #49). Findings Include: 1. Per record review, Resident #4 was admitted on 2/29/2020 with diagnoses of PTSD (Post-Traumatic Stress Disorder), Bipolar Disorder, Schizophrenia, Insomnia, and Major Depressive Disorder. Resident #4's care plan	F 699	1. Resident #4 was assessed by APRN to evaluate the cause of PTSD and identify potential triggers. Trauma care plan has been added to reflect current needs and staff have been made aware. 2. Resident #49 was assessed by APRN to evaluate the cause of PTSD and identify potential triggers. Trauma care plan has been added to reflect current needs and staff have been made aware. 3. None of the residents residing in the facility had negative effects as a result of the alleged deficient practice. 4. Residents residing in the facility that have a past history of trauma have the potential to be affected by the alleged deficient practice. 5. Education provided to the staff regarding trauma-informed care including potential triggers.	

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

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F 699	Continued From page 1 includes focuses of sexually inappropriate behavior, refusal of care, distressed/fluctuating mood symptoms, and sleep pattern disturbance. The admission note from Resident #4's Attending Physician on 3/1/2020 states, "PTSD is service related." The first consult note from the Psychiatric Nurse Practitioner on 2/17/2022 states, "[Resident #4] mentioned serving in Vietnam and 'agent orange'." Per review of Resident #4's record, there was no evidence found that Resident #4 was assessed for triggers that may re-traumatize the Resident. There was also no evidence found in Resident #4's plan of care regarding the Resident's triggers or how staff can provide care that avoids re-traumatizing the Resident. Per interview on 3/22/2023 at approximately 8:30 AM, an LNA (Licensed Nursing Assistant) with 30 years at the facility was unable to identify Resident #4's specific triggers related to their trauma experience. Per interview on 3/22/2023 at approximately 12:30 PM, the facility Administrator and Director of Nursing confirmed that Resident #4's trauma experience and associated triggers are not identified in the Resident's record. 2. Per record review, Resident #49 was admitted on 5/11/2022 with diagnoses of PTSD (Post-Traumatic Stress Disorder), Anxiety, and Depression. Resident #49's care plan includes focuses of verbal behaviors, resistance to care, distressed/fluctuating mood symptoms, and adjustment issues. The Attending Physician admission note from 5/14/2022, the Nurse Practitioner admission note from 5/24/2022, and	F 699	6. Audits will be conducted by the DNS or designee weekly x1 month and then bi-weekly x2 months to monitor effectiveness of the plan. 7. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 8. Corrective action will be completed by May 6, 2023. **Tag F 699 POC accepted on 4/11/23 by S. Freeman/P. Cota**	

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F 699	Continued From page 2 the Psychiatric Nurse Practitioner note from 6/2/2022 all mention that Resident #49 has PTSD but include no additional details about the trauma or associated triggers. Per review of Resident #49's care plan, a care plan intervention from 8/18/2022 states, "Evaluate the nature and circumstances (i.e., triggers) of the verbal behavior with resident/patient and/or resident representative." However, there is no identification in the record of what these triggers are or how they relate to Resident #49's trauma experience. Per interview on 3/22/2023 at approximately 12:30 PM, the facility Administrator and Director of Nursing confirmed that Resident-specific triggers have not been identified or care planned for Residents with a history of trauma.	F 699		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880	PART 1 Resident #149 was immediately placed into a private room and staff was provided education on contact precautions. The Admissions Director was also educated on cohorting guidelines with residents with active C-Diff. 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. Education provided to all staff who enter resident rooms that are on contact precautions for any reason will receive training on contact precautions, and proper use and actions around PPE.	5/6/23

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F 880	Continued From page 3 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880	5. Observational audits will be conducted by the DNS or designee weekly x1 month and then bi-weekly x2 months to monitor effectiveness of the plan. 6. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 7. Corrective action will be completed by May 6, 2023. PART 2 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 that receive medications have the potential to be affected by the alleged deficient practice. 3. All staff who handle or distribute resident medications will receive training on hand hygiene and infection control as it relates to medication administration. 4. Observational audits will be conducted by the DNS or designee weekly x1 month and then bi-weekly x2 months to monitor effectiveness of the plan. 5. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 6. Corrective action will be completed by May 6, 2023.	5/6/23

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F 880	Continued From page 4 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Findings include: 1. On 03/20/23 at 2:08 PM, a staff Licensed Practical Nurse (LPN) was observed in room 112 standing approximately 4 feet from Resident # 149 who is on contact precautions for Clostridium- Difficile (C-Diff). There was another resident in the semi-private room at the time of the observation. This other resident was being treated for chronic venous ulcers. The LPN did not don gloves or a gown as indicated by a Centers for Disease Control (CDC) sign posted on the room door. The contact precautions sign stated that anyone entering the room must don gloves and a gown. The LPN then left the room and proceeded to enter several additional resident rooms without sanitizing or washing hands. Immediately after the observation, the LPN stated that Resident # 149 had C-Diff and that gown and gloves should be worn only when providing personal care which is contrary to facility and CDC policy. CDC and facility policy states that gown and gloves must be worn before	F 880	**Tag F 880 POC accepted on 4/11/23 by S. Freeman/P. Cota**	

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F 880	Continued From page 5 contact with the patient or patient's environment. On 3/22/23 at 10:52 AM, the Director Of Nurses (DON) agreed that staff should have been donning gloves and gowns when entering Resident # 149's room. 2. During observation of the medication administration pass on 3/21/2023 at 8:55 AM the Licensed Practice Nurse (LPN) was observed administering medication to a Resident and then return to the medication cart. S/he then preceded to prepare medications for another Resident, administer them and return to the cart again. S/he then prepared medications for another resident and administered them. During this administration the LPN spilled juice on the floor, cleaned it up with a towel, and then washed her/his hands. During interview at 9:10 AM the LPN confirmed that S/he should performed hand hygiene before, after, and between residents while administering medications.	F 880		