

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

April 21, 2014

Mr. David Lamando, Administrator
Rutland Healthcare And Rehabilitation Center
46 Nichols Street
Rutland, VT 05701-3275

Dear Mr. Lamando:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 2, 2014**. 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

PC:jl

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

PRINTED: 04/07/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/02/2014
NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	F 000		
F 226 SS=D	<p>An unannounced onsite complaint investigation was conducted on 3/24/14 - 3/25/14 by the Division of Licensing and Protection. The investigation was completed on 4/2/14, after further offsite review of materials submitted after the onsite investigation by the facility. The following deficiencies were cited,</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC.POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to report an allegation of potential neglect following an inappropriate transfer for one resident (Resident #1) Findings include:</p> <p>1. On admission to the facility on 3/14/14, transfer information noted that Resident #1 had functional limitations due to left sided hemiparesis (muscle weakness) and required the assistance of two or three using a gait belt for transfers. Hospital records sent on admission also noted that Patient #1 had "... resultant L sided hemiparesis as well as hemineglect essentially presenting with hemiplegia (paralysis) as well as left sided visual loss".</p> <p>On 3/15/14 at approximately 12:00 PM, Resident</p>	<p>The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.</p> <p>F-226 Resident #1's transfer status was reviewed and updated, the LNA was re-educated on our safe resident handling policy which includes establishing and following the resident's transfer status, and if that POC is not followed it may lead to abuse, neglect or mistreatment investigation.. No other residents were negatively impacted by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. An audit of all transfer assessments has been completed and the care plan and kardex have been audited to assure they match, and that the transfer Status of each resident is clear.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administration* (X6) DATE *4/18/14*

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 226	<p>Continued From page 1</p> <p>#1 requested to be toileted. Two LNA's (LNA #1 & LNA #2) physically assisted the resident onto the toilet from h/her wheelchair. LNA #1 said she was aware the resident had left sided weakness. When the resident was finished, Nurse #1 told LNA #1 that two staff would be needed to transfer the resident from the toilet and would assist LNA #1. LNA # 1 returned to the bathroom and proceeded to stand Resident #1 from the toilet to clean h/her without assistance prior to the nurse's arrival. LNA #1 said she asked the resident if h/she was comfortable standing. However, during interview with the surveyor, the resident expressed concern to the LNA about lifting her alone due to h/her height/size and not having anything to grab onto. The LNA said "We'll be fine - just hold on". Resident #1 said h/she was holding onto the wall when h/she told LNA #1 "I'm sliding". LNA #1 said "No you're not" and the LNA loosened the gait belt and slid h/her to the floor. (LNA #1 stated Resident #1 told her "My knee is giving out" and "I'm falling.. I'm falling" before being lowered to the floor.</p> <p>On 3/16/15 while being evaluated by physical therapy, Resident #1 complained of left ankle pain with movement and tenderness on the left distal fibula. The physician was notified and ordered an X-ray. On 3/17/14 following X-rays, Resident #1 was found to have a fractured left ankle.</p> <p>The Interim DNS and Administrator confirmed on 3/25/14 that a report was not filed with Adult Protective Services or the State Licensing Agency.</p>	F 226	<p>Center nursing staff will be re-educated by the DNS or her designee on the policy & procedure for determining transfer status and the importance of following the care plan. They will also be educated on reporting requirements for potential abuse, neglect or mistreatment and also as it relates to not following the plan of care.</p> <p>Administrator or designee will conduct weekly audits of the accident & incident report comparing it to the care plan and Kardex for 3 weeks to ensure transfer status compliance, and then monthly for 3 months.</p> <p>The results will be reviewed at the QA meeting for further review and recommendations.</p> <p>Date of compliance: 5-1-14 POC accepted 4/11/14 F323 #1's partic. Adm skenya RW Resident #1's transfer status was Updated on her plan of care and the staff have been educated on proper transfer technique for this patient. The social worker has been assigned to follow this resident's case. The social worker will meet with this resident and will review all accidents & incidents for this resident assuring that the care plan was being followed.</p>
F 323 SS=D	483.26(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	

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F 323	Continued From page 2 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview and observations, the facility failed to assure that each resident received adequate assistance to prevent accidents. (Resident #1) Findings include: 1. On admission to the facility on 3/14/14, transfer information noted that Resident #1 had functional limitations due to left sided hemiparesis (muscle weakness) and required the assistance of two or three using a gait belt for transfers. Hospital records sent on admission also noted that Patient #1 had "...resultant L sided hemiparesis as well as hemineglect essentially presenting with hemiplegia (paralysis) as well as left sided visual loss". Admission nursing notes dated 3/14/14 @ 16:15 stated "Type: Assessment, Note Text: A Lift-Transfer-repositioning Evaluation was completed today resulting in a Lift Designation of "Sit to Stand Lift" and a Positioning in bed designation of "No equipment needed for positioning in bed...See assessment UDA (Used Defined Assessment) for detailed findings." Based on record review, the initial care plan of	F 323	No other residents were negatively impacted by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. An audit of all resident's transfer status has been conducted to ensure the resident transfer status matches the care plan, is clear and is being followed. Center staff will be re-educated on the policy & procedure for determining the transfer status, safe resident handling techniques and the importance of following the plan of care. Director of Nursing or designee will conduct weekly audits of the care plan and Kardex to ensure compliance. This Audit will be done weekly for 3 weeks and then monthly for 3 months with results to being reported to the QA committee for further review and recommendations. Additionally each unit manager will audit transfers being performed on their units. Date of compliance: 5-1-14 <i>POC accepted ylatlm shuryro</i>		

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F 323	<p>Continued From page 3</p> <p>3/14/14 identifying Resident #1 as being a fall risk did not include the "Sit to Stand Lift" and was not on the "Kare Cards" used by the Licensed Nursing Assistants (LNA). This was confirmed by the Interim DNS on 3/24/14 @ 4:05 PM.</p> <p>On 3/15/14 at approximately 12:00 PM, Resident #1 requested to be toileted. Two LNA's (LNA #1 & LNA #2) physically assisted the resident onto the toilet from h/her wheelchair. LNA #1 said she was aware the resident had left sided weakness. When the resident was finished, Nurse #1 told LNA #1 that two staff would be needed to transfer the resident from the toilet and would assist LNA #1. LNA # 1 returned to the bathroom and proceeded to stand Resident #1 from the toilet to clean h/her without assistance prior to the nurse's arrival. LNA #1 said she asked the resident if h/she was comfortable standing. However, during interview with the surveyor, the resident expressed concern to the LNA about lifting her alone due to h/her height/size and not having anything to grab onto. The LNA said "We'll be fine - just hold on". Resident #1 said h/she was holding onto the wall when h/she told LNA #1 "I'm sliding". LNA #1 said "No you're not" and the LNA loosened the gait belt and slid h/her to the floor. (LNA #1 stated Resident #1 told her "My knee is giving out" and "I'm falling.. I'm falling" before being lowered to the floor.</p> <p>Resident #1 told the surveyor that h/her left foot was in "a funny position" and "turned inward" after landing on the floor. LNA # 1 said "I'm sorry.. I'm going to have to get more help" and left the room. Four staff returned to use a Hoyer lift (mechanical lift used for transfers) to assist Resident #1 off the floor into bed. LNA #1 reported that Resident #1 complained that her left leg hurt when lifted into</p>	F 323		
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F 323	<p>Continued From page 4</p> <p>bed. Over the next two days, Resident #1 continued to have intermittent pain in both legs requiring the use of pain medication. When the pain persisted following a physical therapy evaluation on 3/16/14, the physician ordered an x-ray of the left leg. Resident #1 was found to have a fractured ankle on 3/17/14.</p> <p>During interviews on 3/24/14 & 3/25/14, LNA's # 1, # 2 & # 3 stated they were not provided with any information by nursing concerning Resident #1's transfer ability. During interviews on 3/24/14, LNA's #1 and #2 said the night LNA's reported that two staff were needed for assistance although Resident #1 had not been out of bed on 3/14/14. LNA #2 stated during interview on 3/24/14 @ 12:57 PM "I didn't know if it was safe for her to be alone". LNA #3 stated during interview on 3/25/14 @ 11:20 AM "We had no information.. the nurse said there was no paperwork that said how to transfer [Resident #1]".</p> <p>Per interview on 3/24/14 @ 11:20 AM, Nurse #1, said Resident #1, who was dependent on staff for care, would not have been moved until seen by physical therapy. Nurse #1 didn't know how Resident #1 was transferred onto the toilet but found h/her there when she went to administer medication on 3/15/14. Nurse #1 told the resident she need to get help to move h/her and asked LNA #1 for help. Nurse #1 was speaking to the Supervisor when she told LNA #1 not to move the resident and two were needed for transfer assistance "but she did anyway". Nurse #1 confirmed that the use of the "Sit to Stand Lift" was not communicated to the LNA's.</p> <p>Per interview on 3/24/14 @ 1:29 PM, the physical</p>	F 323		
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F 323	<p>Continued From page 5</p> <p>therapist stated h/she was unsure if a resident has to remain in bed until seen by PT. "I'm not sure I have to see patient's prior to getting up". When seen for evaluation on 3/16/14, the evaluation was stopped due to Resident #1's complaint of discomfort. PT recommended further diagnostics when the nurse said portable x-ray would be done Monday.</p> <p>2. Per observation on 3/25/14 @ 10:40 AM, three LNA's assisted Resident #1 from bed into a wheelchair using a Hoyer lift. LNA #2 tilted the wheel chair back as the lift was lowered. LNA # 2 confirmed tilting the chair back to avoid having to reposition and pull the resident up in h/her chair. "I was taught by another LNA to do this...not everyone does this.." per LNA #2. Per review of the "Safe Resident Handling Equipment" policy and procedure and interview with the Interim DNS on 3/25/14 @ 12:30 PM, staff training does not include tipping chairs back which could result in injury to residents and/or staff.</p>	F 323		
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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNEs AND NFEs	PROVIDER # 475039	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 4/2/2014
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NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION (STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the care plan was not revised with a new medical problem for one of three residents. (Resident # 3) Findings include:

Following a fall on 3/16/14 that resulted in complaints of head, neck, back, and rib pain, Resident #3 was sent to the Emergency Department for evaluation. The resident was admitted with a compression fracture of the lumbar spine and returned to the facility on 3/19/14. Based on review of the care plan dated 2/27/14, the compression fracture was not identified. This was confirmed by the Interim DNS on 3/25/14.

*This is an "A" level citation, and while the facility is required to correct the issue identified, no plan of correction is required.

F 514 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to completely and accurately document a resident's a fall for 1 of 3 residents in the sample. (Resident #1.) Findings include:

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

The above isolated deficiencies pose no actual harm to the residents

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AN
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475039	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 4/2/2014
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F 514	<p>Continued From Page 1</p> <p>I. The medical record for Resident #1 did not provide complete documentation related to a fall that occurred on 3/15/14.</p> <p>Per review of a facility incident report dated 3/15/14, which is not part of the medical record, the report stated that Resident #1's "leg gave out" and h/she was lowered to the floor while being assisted by one LNA after using the toilet.</p> <p>The nursing note at 3/15/14 @ 12:59 for "Change in Condition" stated the resident "had a(n) accident/incident/fall in past 72 hours, witnessed. (h/her) bathroom." The nursing note did not describe the resident's complaint that h/her "leg gave out" which resulted in being lowered to the floor. The note did not include the need for mechanical lift with four staff to assist Resident #1 from the floor. This was confirmed during interview with the Interim DNS on 3/24/14 @ 4:05 PM.</p> <p>*This is an "A" level citation, and while the facility is required to correct the issue identified, no plan of correction is required.</p>