

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

June 18, 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 **May 14, 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

RECEIVED
Division of
PRINTED: 05/28/2014
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 _____	JUN 10 14 Licensing and Protection	(X3) DATE SURVEY COMPLETED C 05/14/2014
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NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT 05701
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F 000	INITIAL COMMENTS An unannounced onsite annual recertification survey was conducted by the Division of Licensing and Protection from 5/12/14 - 5/14/14. There were regulatory violations related to the recertification survey.	F 000	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.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review the facility failed to ensure that services provided or arranged by the facility meet professional standards for 1 of 22 residents, (Resident #58). The findings include: The facility failed to ensure for Resident #58, that physician orders for laboratory testing be carried out as requested after the initiation of a new thyroid medication. Per medical record review on 4/13/14 at approximately 1:30 PM, physician visit dated 2/6/14 identified that Resident #58 is diagnosed with mild hypothyroidism. Plan to start Levothyroxine 25 mcg daily and recheck labs on 3/12/14. Per medical record review on 4/13/14 at approximately 1:30 PM, physician order dated 2/6/14 documents Levothyroxine 25 mcg by mouth (PO) daily and on 3/12/14 draw blood for Thyroid Stimulating Hormone and Free T4.	F 281	F281 Corrective action for those residents found to be affected: The attending physician was notified and the lab tests were completed for the resident identified. Appropriate orders were initiated and follow up labs will be ordered. Identification of other residents that have the potential to be affected: All residents that have lab orders for Thyroid testing have the potential to be affected. An audit of labs ordered within the last 3 months will be done by the DNS/designee. Measures put in place to ensure this practice does not reoccur: Licensed nurses will be re-in serviced on our system for picking up lab orders and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <u>Administrator</u>	(X6) DATE <u>6/16/14</u>
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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 281	Continued From page 1	F 281	following through to ensure they are completed.		
F 353 SS=E	<p>Per medial record review on 4/13/14 at approximately 1:30 PM, there is no evidence demonstrating that the laboratory tests were drawn as ordered nor is there evidence of results of ordered laboratory studies.</p> <p>Per interview with Unit Manger (UM) on 4/13/14 at approximately 2:16 PM confirmation was made that the laboratory studies were never conducted.</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 353	<p>Monitoring to ensure the deficient practice does not reoccur:</p> <p>The DNS/designee will randomly audit lab orders to ensure they are being completed. Results of the audit will be reported monthly to the QI committee for further review and recommendations.</p> <p><i>F281 POC accepted 6/17/14 RTremblay RN/PMC</i></p> <p>F 353</p> <p>Corrective action for those residents found to be affected:</p> <p>A meeting will be held with those residents identified to focus on specific incidences when care was delayed. Their plan of care will be modified to meet their needs.</p> <p>Identification of other residents that have the potential to be affected:</p> <p>A meeting was held with the president of resident council. She stated she has never heard a compliant about staffing or timely care not being provided, but would add this topic to the agenda going forward. An audit of call bell response time will be conducted randomly by the DNS/designee to monitor for timeliness of response.</p>	<p><i>6/20/14</i> <i>7/1/14</i></p>	

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F 353	<p>Continued From page 2</p> <p>Based on observation, resident interview and record review the facility failed to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care for 9 of 36 residents in both Stage 1 and Stage 2 samples. The Residents included are #20, 51, 96, 129, 44, 31, 110 and 56. The findings include the following:</p> <p>1. Per interview on 5/14/14 at approximately 11:30 AM, Resident #20 confirmed that h/she is tired of waiting for his/her needs to be met. H/She constantly feels rushed while Licensed Nurses Aides (LNA) provide personal care, staff do not meet his/her requests of returning personal belonging back where they belong and staff can not complete the care that all of residents need with the few LNA's that are assigned daily. Per record review, Resident #20 admitted on 12/23/13 with a diagnosis of Post Polio Syndrome and fracture of the right tibia and fibula, requires extensive assistance with Activities of Daily Living (ADL's), to include bathing, dressing, toileting, grooming and all transfers.</p> <p>2. Per resident interviews on 5/12/14, during the Stage I resident interview process, Residents #51, #96, #129, #44, #31 and #56 identified that there was not enough staff to assist them when they needed assistance without having to wait too long.</p> <p>Residents #96, #129, #56, #51 and #31 indicated in interview on 5/12/14 that there was not enough staff on the evening shift to meet the residents needs without having to wait.</p>	F 353	<p>Measures put in place to ensure this practice does not recur:</p> <p>The social work will meet with those residents that specifically complained once per week. This meeting will focus on specific incidences, if any, where care was not delivered in a timely fashion. Staff will be re-in-service to assure that call bells are answered timely and that it is everyone's responsibility to answer call bells.</p> <p>Monitoring to ensure the deficient practice does not recur:</p> <p>Any issues brought up at either the resident council meeting or the social worker meeting will be brought to the DNS's attention immediately. Corrective action will be taken and the incident brought to the monthly QA meeting. Call bell audits will be conducted randomly to assure the residents' needs are being met. All findings will be brought to the QA committee for review and further recommendations.</p> <p><i>F353 POC accepted 6/17/14 RTremblay RN/ PML</i></p>	<p><i>7/1/14</i> <i>6/20/14</i></p>

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F 353	Continued From page 3 Residents #44 and #31 indicated during interview on 5/12/14 that they have waited from 30 minutes to 60 minutes, which #44 and #31 indicated is a long time to get assistance. 3. Per resident interview during stage 1 of the survey, Resident #110 stated that the evening shift has only 2 LNA's. The resident also stated that h/she had to wait 15-20 minutes for call lights to be answered on all shifts.	F 353	F371 Corrective action for those residents found to be affected: There were no specific residents found to be affected. Identification of other residents that have the potential to be affected:		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store, prepare, distribute and serve food under sanitary conditions. Findings include that 2 of the 5 unit kitchenettes did not have properly labeled or dated foods: 1. Per observation on Unit 3 South, during a tour of the nourishment kitchen, on 5/14/14 at 8:00 AM, there was an opened box of dry cereal on a shelf above the counter, that was not dated as to when the box was opened. The refrigerator	F 371	All residents have the potential to be affected. All refrigerators have been inspected and cleaned. New signs have been placed on the refrigerators clearly stating that unmarked food is not to be placed in this refrigerator. The ice scoop on the third floor south side has been replaced and all other units were checked and the ice scoops were found to be in place. Measures put in place to ensure this practice does not reoccur: Staff were re-in serviced on the requirement to properly label food items before placing them in the refrigerator. The Dietary Director/designee will make daily rounds to inspect the unit refrigerators and placement of ice scoops. Any food items		

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F 371	Continued From page 4 presented with five (5) containers that were not labeled as to the content and the date to use by. Per confirmation at 8 AM with the Registered Nurse (RN), three (3) of the containers appeared to contain peaches. The other two containers were coffee mugs with covers and unknown what the contents were and they were not labeled. 2. Per observation of the 3rd floor South Unit kitchenette, at 8 AM on 5/14/14, there was an ice cooler that contained ice cubes. There was no evidence of a scoop for ice removal for individual residents to use or to have in the water pitchers on the medication cart. Per interview and confirmation with the RN floor nurse at this time, there is supposed to be a scoop for the ice cooler and h/she uses a cup to get the ice from the cooler, but is unsure if others do the same. H/she stated that the scoop has been missing for a while. 3. On 5/14/14 at 9:00 AM per observation of 2nd floor North kitchenette, with the Licensed Practical Nurse (LPN), there were two (2) containers of unlabeled foods, and one of them (a peach crisp) did not have any covering. The LPN confirmed at this time that the foods were not dated, labeled or covered. Per interview with the Food Service Director (FSD) on 5/14/14 at 10:50 AM, peaches are served on an individual resident's tray at lunch and dinner every day and the floor staff will place them in the unit refrigerator for later if the resident doesn't want to eat them with the meal. The FSD further stated that peach crisp was served to the residents on 5/13/14 with the dinner meal.	F 371	found not to be properly labeled will be disposed of. Any ice scoop found missing will be immediately replaced. Monitoring to ensure the deficient practice does not recur: Staff has been in-serviced that they are to use an ice scoop when serving ice. If one is not present they are to notify dietary immediately. The dietary director will develop a QA tracking tool that will track the number of items found not labeled and the unit and time they were found. This tracking tool will also include an audit of ice scoops. She will report the results of this tracking tool monthly at QA. The QA committee will review the audits and make recommendations as necessary. F371 ROC accepted 6/17/14 RTVembday Ral/Pmc	6/20/14 7/1/14	
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT	F 387	Corrective action for those residents found to be affected: The attending physician has been notified of those residents cited and corrective action		

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F 387	Continued From page 5 The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure 5 of 26 residents in the stage 2 sample were seen by a physician in a timely manner (Residents # 63, #1, #53, #58 & #26). Findings include: 1. Per record review on 5/14/14 at 7:30 AM, Resident # 63 was last seen by a physician 75 days ago. Per record review, The last physician visit was on 2/28/14. On 5/14/14 at 8:54 AM, the Unit Manager (UM) confirmed that the physician has not seen the resident in the past 60 days as required. 2. Resident #1 was last seen by the attending physician on 2/6/14. Per medical record review of Resident #1, on 5/14/14 at approximately 10:30 AM, physician progress note evidences that the last visit is dated 2/6/14. Resident #1 has diagnosis to include Epilepsy, Hypothyroidism, Dysphagia, Edema and Dementia. Per interview with the Unit Manger (UM) on 5/14/14 at 11:07 AM s/he confirms that the physician has not seen the resident since 2/6/14. 3. Resident #53 was last seen by the attending	F 387	has been taken to bring these residents into compliance. Identification of other residents that have the potential to be affected: All residents have the potential to be affected. A complete audit of all current residents will be completed. Any resident that is not in compliance will be brought into compliance. Measures put in place to ensure this practice does not reoccur: Education of medical records staff, Licensed Nurses and medical personnel has occurred explaining the required visits that must be made by a doctor. Monitoring to ensure the deficient practice does not recur: The medical records staff will audit all residents monthly for compliance with regularly scheduled physician visits. The results of this audit will be reported monthly to the QA committee for review and further recommendations.		

F387 POC accepted 6/17/14 RTTembolay RN/pmc

~~6/20/14~~
6/20/14

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F 387	<p>Continued From page 6</p> <p>physician on 2/7/14. Per medical record review of Resident #53, on 5/14/14 at approximately 10 AM, physician progress note evidences that the last visit is dated on 2/7/14. Resident #53 has diagnosis to include Paranoid Schizophrenia, Congestive Heart Failure, Depression and Hypertension. Per interview with the Unit Manger (UM) on 5/14/14 at 10:51 AM s/he confirms that the physician has not seen the resident since 2/7/14.</p> <p>4. Resident #58 was last seen by the attending physician on 2/6/14. Per medical record review of Resident #58, on 5/13/14 at approximately 2:20 PM, physician progress note evidences that the last visit is dated on 2/6/14. Resident #58 has diagnosis to include Dementia, Hypertension, Anxiety, Depression and Osteoporosis. Per interview with Unit Manager (UM) on 5/13/14 at approximately 2:16 PM s/he confirms that the physician has not seen the resident since 2/6/14.</p> <p>5. Per record review on 5/14/14, the last physician's progress note filed for Resident #26 is labeled 60 day review and is dated 1/31/14. Per review of Nursing Notes for 3/31/14 the resident was seen on psychiatric consult via 'telepsych', with the telepsych recommendations "printed off and presented to MD for evaluation." Per review of Resident #26's printed and electronic medical record, there is no copy of the printed recommendations or documentation that the physician had reviewed or seen the recommendation. Additionally, there was no documentation in Resident #26 printed and electronic medical record that the resident's physician had seen and assessed the resident face to face as required by regulation after the last physician progress note dated 1/31/14.</p>	F 387			

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F 425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. Findings include:</p> <p>During medication administration observation for Resident #158 on 5/12/14 at 10:28AM, the nurse prepared all medications ordered for the resident for the morning medication pass, except for a Nicotine Patch 14mg to be applied topically daily</p>	F 425	<p>F425</p> <p>Corrective action for those residents found to be affected:</p> <p>The nicotine patch was immediately order and placed on the resident.</p> <p>Identification of other residents that have the potential to be affected:</p> <p>Residents with orders for nicotine patches have the potential to be affected and have been audited to assure that the medication is available.</p> <p>Measures put in place to ensure this practice does not reoccur:</p> <p>Staff that administers medications were re-in serviced on the procedure to be followed should a medication be unavailable.</p> <p>Monitoring to ensure the deficient practice does not recur:</p> <p>The DNS/designee shall monitor monthly residents' MARS to assure that if a medication is available. This audit will be reported monthly to the QA committee for further follow up and recommendations.</p>	6/20/14 7/1/14	

F425 POC accepted 6/17/14 R Tremblay RN / PML

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F 425	Continued From page 8 and removed in 24 hours. H/she proceeded to Resident #158 room to administer his/her other medications. During the administration of these medications, the LPN informed the resident that h/she did not have the Nicotine Patch on the medication cart and h/she would check the Pxyxis (a pre-filled medication storage unit that houses medications to use for emergency supply) for him/her. At this time, Resident #158, stated that h/she hoped h/she had one because h/she had not had a patch in three days. The LPN removed a Nicotine Patch from Resident #158 upper right arm and confirmed that the patch was dated as being applied on 5/8/14, four days ago. The LPN also checked for placement of a patch in different applicable parts of the body for Resident #158 and there were none found. The resident stated that h/she is ready to get up and go across the street to get a pack of cigarettes and then when the LPN told him that h/she did not think that Physical Therapy was ready for him/her to do that, h/she stated that he would get into his wheelchair and go. Resident #158 asked if there was a gate on the back fence to go through so h/she would not have to cross traffic. The Licensed Practical Nurse (LPN) went to check the Pxyxis and discovered there were no Nicotine 14mg patches to dispense. Review of the Medication Administration Record (MAR) on 5/12/14 at 10:45AM presented that Nicotine Patch was applied on 5/8/14. Initials were circled for 5/9/14 and again on 5/10/14. Per the LPN at this time h/she indicated that circled initials met that a medication was not given. There was no documentation in the nurse progress note or on the MAR as to reason not applied.	F 425		
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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(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 431 SS=D	<p>Continued From page 9</p> <p>LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>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.</p> <p>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 be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the</p>	F 431	<p>F431</p> <p>Corrective action for those residents found to be affected:</p> <p>No specific resident was cited.</p> <p>Identification of other residents that have the potential to be affected:</p> <p>Residents receiving injectable medications have the potential to be affected.</p> <p>Measures put in place to ensure this practice does not reoccur:</p> <p>Nurses that pass medications will be re-instructed on our policy and procedure on dating medications when opened. This instruction will also include checking the date on all medication prior to administering them and disposing of any outdated medication immediately.</p> <p>Monitoring to ensure the deficient practice does not recur:</p> <p>The DNS/designee will audit drug storage areas weekly for 2 months and inspect all open medications for proper label and dating, and look for any outdated medications.</p>		

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

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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 05/14/2014
NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT 05701		
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F 431	Continued From page 10 facility failed to adhere to pharmacy storage practices of disposing/destroying drugs and biologicals. Findings include: 1. On 5/14/14 at 8:34AM during observation of medication storage, the facility failed to dispose of medications that were dated past the manufacturer recommendations for use after opening. On 3rd floor South, inspection of medication storage refrigerator presented with an opened partially used vial of house stock Tuberculin that was without a date. Confirmation was made at 8:25AM by the Registered Nurse (RN) Unit manager that the vial was open and not dated and that the medication is to be used within 30 days, per labeling of the vial and manufacturers recommendation. 2.) On 5/14/14 at 8:40AM, per observation of the 3rd south medication cart, there was an opened bottle of Novolog insulin dated as being opened on 4/8/14 for a resident and it was still in use for the resident. Manufacturer recommendation is to discard 28 days after opening. Confirmation was made at time of discovery, with the Licensed Practical Nurse that the insulin was open it should have been discarded after 28 days..	F 431	Results of these audits will be reported to the QA committee monthly for further review and recommendations. F431 POC accepted 6/17/14 RTrembyRN/rmc	6/20/14 7/1/14	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM OR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY
	475039	A. BUILDING: _____ B. WING _____	COMPLETE: 5/14/2014

NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION C	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT
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REFX AG	SUMMARY STATEMENT OF DEFICIENCIES
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F9999 FINAL OBSERVATIONS

State Regulation

3.14 Transfer and Discharge:

(d) Notice before transfer or discharge. Before a facility transfers or discharges a resident, the facility must:

(1) Notify the resident, if known, a family member, including a reciprocal beneficiary, or legal representative of the resident of the proposed transfer or discharge and the reasons for the move. The notice shall be in writing and in a language and manner they understand, and shall be given at least 72 hours before a transfer within the facility and 30 days before the discharge from the facility.

Based on record review and staff interview the facility failed to ensure that 1 of 2 residents identified received notification of a room change prior to the actual move. The findings include:

Per record review Resident #35 received notification of a room change on 5/7/14. The room change notification letter dated 5/7/14 indicates that the effective date of the room change is 5/7/14. The notification letter also indicates that "State regulations require us to notify in writing, the resident and, his/her legal representative of a proposed transfer or discharge and the reasons for the move at least 72 hours before a transfer within the facility and 30 days before the discharge from the facility."

Per interview on 5/14/14, the facility Social Worker reviewed the Room Change notification letter, and he/she confirmed that Resident #35 was not given the required 72 hours notice prior to the transfer within the facility.

State regulation 3.14

Corrective action for those residents' identified: This resident's chart was reviewed during survey and it was noted that the social worker did not write that the resident agreed to the move and volunteered to move prior to the 72 hours elapsing.

Identify other residents that may be affected: Any resident that agrees to be moved during the 72 hour waiting period is at risk. Social Service has reviewed the state requirement and will document on any resident that is moved prior to the 72 hour time period elapsing.

Monitoring: All 72 hour notices will be reviewed monthly by the Social worker/designee and a report generated for the QA committee. The Social Worker will present this report to the QA committee for further action.

Date of completion: 06/11/2014 *F9999 POC accepted 6/17/14 RYemby RN/AMC*

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