

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

August 6, 2013

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

Dear Mr. Dingman:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 9, 2013**. 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
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Licensing and
Protection
PRINTED: 07/22/2013
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 07/09/2013
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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	F 000		
F 223 SS=E	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that 3 of 3 residents identified (Resident 1, #2 and #3 were free from physical abuse. The findings include;</p> <p>1. Per review of the facility internal investigation dated 1/25/13, Resident #1 was passing out silverware in the dining room and offered silverware to Resident #2. Resident #2 did not want the silverware and slapped Resident #1 causing scratches to Resident #1.</p> <p>Per review of the medical record on 7/8 and 7/9/13, Resident #1 was admitted to the facility on 11/12/12 and had diagnosis that include Alzheimer's and dementia with behavioral disturbances. Resident #2 was admitted to facility on 10/13/10 with diagnosis that include,</p>	F 223	<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 Tag 223</p> <ul style="list-style-type: none"> ✓ Correction: Resident # 1 no longer resides in the facility. Residents # 2 & #3 have had their care plans reviewed and revised. ✓ Identify Other Potential Residents: All residents on 3 North have the potential to be affected by the alleged deficient practice. ✓ Systemic Changes: Center licensed nursing staff will be re-educated on the policy and procedure for abuse prevention. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Director of Nursing* (X6) DATE *8/2/13*

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.

pmc

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F 223	<p>Continued From page 1</p> <p>Alzheimer's and Dementia with behavioral disturbances and mixed receptive-expressive language disorder.</p> <p>The medical record indicates that Resident #2 has a history of aggressive behavior. The progress notes indicate that Resident #2 and Resident #1 were involved in a verbal altercation on 1/6/13. The comprehensive care plan for Resident #2 for behaviors was updated on 1/6/13 and indicated that Resident #1 would have triggers identified and reduce Resident #2's exposure to them.</p> <p>Per interview with the DNS and UM, on 7/9/13, they confirmed that the facility failed to implement care plan interventions specific to the needs of Resident 2 to help reduce and prevent abuse from occurring.</p> <p>2. Per review of the facilities internal investigation dated 3/18/13, Resident #1 and Resident #2 were involved in an altercation in the hallway on 3/16/13. The investigation indicated that Resident #2 was sitting in the hallway in a chair. Resident #1 approached Resident#2 and leaned into the personal space of Resident #2. Resident #2 then scratched the right side of Resident #1's face, upper arm and inner arm. The investigation indicates that then Resident #1 scratched Resident #2's right inner arm.</p> <p>Per review of the medical record there was no evidence that the facility staff had redirected Resident #1 out of the personal space of Resident #2 prior to the 3/18/13 altercation and there was no evidence in the medical record that indicated that Resident #2 was assessed and</p>	F 223	<p>✓ Monitoring: DNS or designee will conduct weekly audits x 3 months on 3 North residents on the implementation of care plan interventions specific to the needs of the individual resident to help reduce and prevent abuse from occurring with results to be reviewed at QA meeting for further evaluation and recommendations</p> <p>Responsibility: Director of Nurses</p> <p>Date of Compliance: 8/9/2013</p> <p><i>F223 POC accepted 8/5/13 McLellan/RN/PMC</i></p>	
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F 223	<p>Continued From page 2</p> <p>triggers for aggressive behavior towards others identified and exposure to those triggers be reduced.</p> <p>The DNS and UM were unable to provide evidence that Resident #2 was assessed after 1/6 and before 3/18/13 and triggers to potential aggressive behaviors was identified. The DNS and UM also were unable to provided evidence that facility staff had redirected Resident #1 out of the personal space of Resident #2 prior to the 3/18/13</p> <p>Per interview with the DNS and UM, on 7/9/13, they confirmed that the facility failed to implement care plan interventions specific to the needs of Resident #1 and #2 to help reduce and prevent abuse from occurring.</p> <p>3. Per the facility's internal investigation dated 5/14/13, Resident #1 was seen by a facility nurse walking down the hallway, saw through a partially obstructed view Resident #3 started to stand up, the facility nurse indicated that he/she observed Resident #1 with his/her hands around the wrists of Resident #3 and Resident #3's hands around the wrists of Resident #1, the facility nurse yelled for a facility aide who was in the dining room. The facility LNA turned around and observed Resident #1 and Resident #3 holding each others wrists and rocking back and forth and than the LNA observed Resident #1 fall to the ground.</p> <p>Per review of the medical record Resident #3 was admitted to the facility on 2/4/13 and had diagnosis that included dementia with behavioral disturbances.</p>	F 223		

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F 223	<p>Continued From page 3</p> <p>Per review of the comprehensive behavior care plan for Resident #1, the care plan indicates that Resident #1 was to "be removed from environment when [Resident #1] is invading other residents space," (dated 3/16/13), "identify behavior triggers and reduce exposure to them (dated 3/16/13), "closely monitor resident when near other residents for signs of aggression and separate residents immediately if detected. (dated 4/4/13). Per review of the medical record there was no evidence that the facility staff utilized any of the interventions listed on the care plan to assist Resident #1 with his/her potential issues and prevent reoccurrence.</p> <p>Per the DNS and UM confirmed in interview on 7/9/13, after reviewing the comprehensive care plan and medical record of Resident #1, they confirmed that there was no evidence that staff had utilized the interventions on the care plan for Resident #1. Specifically, that, Resident #1 was to "be removed from environment when Resident #1 is invading other residents space, (dated 3/16/13), "identify behavior triggers and reduce exposure to them (dated 3/16/13), "closely monitor resident when near other residents for signs of aggression and separate residents immediately if detected. (dated 4/4/13).</p> <p>Per review of the medical record and facility internal investigation the DNS and UM confirmed that the facility staff in there statements regarding the 5/14/13 incident that the nurse had an obstructed view of the residents and that the LNA at the time of occurrence had his/her back to Resident #1 and #2. Per review of the comprehensive care plan the DNS and UM confirmed that there was no evidence that staff</p>	F 223			

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F 223	Continued From page 4 had utilized the interventions on the care plan for Resident #1. Specifically, that, Resident #1 was to "be removed from environment when Resident #1 is invading other residents space, (dated 3/16/13), "identify behavior triggers and reduce exposure to them (dated 3/16/13), "closely monitor resident when near other residents for signs of aggression and separate residents immediately if detected. (dated 4/4/13). Per interview with the DNS and UM, on 7/9/13, they confirmed that the facility failed to implement care plan interventions specific to the needs of Resident #1 to help reduce and prevent abuse from occurring.	F 223			
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that 3 of 3 residents identified (Resident #1, #2 and #3) had services provided or arranged by the facility by qualified persons in accordance with each resident's written plan of care. The findings include; 1. Per review of the facility internal investigation dated 1/25/13, Resident #1 was passing out silverware in the dining room and offered silverware to Resident #2. Resident #2 did not want the silverware and slapped Resident #1	F 282	F Tag 282 Correction: Resident # 1 no longer resides at the facility. Residents # 2 & #3 have had their care plans reviewed and revised. ✓ Identify Other Potential Residents: All residents 3 North have the potential to be affected by the alleged deficient practice. ✓ Systemic Changes: Licensed Center staff will receive re-education on policy and procedure for care planning.		

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F 282	<p>Continued From page 5 causing scratches to Resident #1.</p> <p>Per review of the medical record on 7/8 and 7/9/13, Resident #1 was admitted to the facility on 11/12/12 and had diagnosis that include Alzheimer's and dementia with behavioral disturbances. Resident #2 was admitted to facility on 10/13/10 with diagnosis that include, Alzheimer's and Dementia with behavioral disturbances and mixed receptive-expressive language disorder.</p> <p>The medical record indicates that Resident #2 has a history of aggressive behavior. The progress notes indicate that Resident #2 and Resident #1 were involved in a verbal altercation on 1/6/13. The comprehensive care plan for Resident #2 for behaviors was updated on 1/6/13 and indicated that Resident #1 would have triggers identified and reduce Resident #2's exposure to them.</p> <p>Per review of the medical record there was no evidence that the facility had identified Resident #1 as being a potential trigger for aggressive behavior.</p> <p>Per interview with the Director of Nursing (DNS) and Unit Manager (UM) on 7/9/13, the DNS and UM reviewed the medical record and internal investigation and confirmed that Resident #1 was involved in a verbally aggressive conversation on 1/6/13 with Resident #2. The DNS and UM confirmed that on 1/25/13 Resident #1 was scratched by Resident #2 in the dining room after Resident #1 attempted to pass silverware to Resident #2 who did not want the silverware. The DNS and UM confirmed after review of the</p>	F 282	<p>✓ Monitoring: DNS or designee will conduct weekly audits x 3 months on 3 North Residents on the implementation of care plan interventions with results to be reviewed at QA meeting for further evaluation and recommendations.</p> <p>Responsibility: Director of Nurses</p> <p>Completion date: 8/9/2013</p> <p><i>F282 POC accepted 8/15/13 McLuhanR/PMC</i></p>	
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F 282	<p>Continued From page 6</p> <p>comprehensive care plan for Resident #2 that the facility staff was to "identify triggers and reduce Resident #2's exposure to them." The DNS and UM confirmed that Resident #1 was a potential trigger of aggressive behavior for Resident #2 based on Resident #1 and #2's previous history of a verbal altercation on 1/6/13. The DNS and UM were unable to provide evidence that Resident #2 was assessed after 1/6 and before 1/21/13 and triggers to potential aggressive behaviors was identified.</p> <p>Per interview with the DNS and UM, on 7/9/13, they confirmed that the facility failed to implement care plan interventions specific to the needs of Resident 2 to help reduce and prevent abuse from occurring.</p> <p>2. Per review of the facilities internal investigation dated 3/18/13, Resident #1 and Resident #2 were involved in an altercation in the hallway on 3/16/13. The investigation indicated that Resident #2 was sitting in the hallway in a chair. Resident #1 approached Resident#2 and leaned into the personal space of Resident #2. Resident #2 than scratched the right side of Resident #1's face, upper arm and inner arm. The investigation indicates that than Resident #1 scratched Resident #2's right inner arm.</p> <p>Per review of the comprehensive care plan for Resident #1, the care behavior care plan indicated that "redirect away from others when resident is entering another residents personal space." This entry was dated 11/19/12. There was no evidence in the medical record that staff had attempted to redirect resident #1 out of the personal space of Resident #2 to prevent the</p>	F 282			

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F 282	<p>Continued From page 7 altercation.</p> <p>Per review of the comprehensive care plan for Resident #2 for behaviors was updated on 1/6/13 and indicated that Resident #1 would have triggers identified and reduce Resident #2's exposure to them.</p> <p>Per review of the medical record there was no evidence that the facility had redirected Resident #1 out of the personal space of Resident #2 prior to the 3/18/13 altercation and there was no evidence in the medical record that indicated that Resident #2 was assessed and triggers for aggressive behavior towards others identified and exposure to those triggers be reduced.</p> <p>The DNS and UM confirmed after review of the comprehensive care plan for Resident #1 the behavior care plan indicated that Resident #1 was to be "redirect away from others when resident is entering another residents personal space." This entry was dated 11/19/12.</p> <p>The DNS and UM confirmed in interview after reviewing the comprehensive care plan and medical record of Resident #2 that there was no evidence that staff had assessed Resident #2 and was able to "identify potential triggers of aggressive behavior and reduce Resident #2's exposure to them." The DNS and UM confirmed that Resident #1 was a potential trigger of aggressive behavior for Resident #2 based on Resident #1 and #2's previous history of a verbal altercation on 1/6/13 and a physical altercation on 1/25/13. The DNS and UM were unable to provide evidence that Resident #2 was assessed after 1/6 and before 3/18/13 and triggers to</p>	F 282			

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F 282	<p>Continued From page 8</p> <p>potential aggressive behaviors was identified.</p> <p>Per interview with the DNS and UM, on 7/9/13, they confirmed that the facility failed to implement care plan interventions specific to the needs of Resident #2 to help reduce and prevent abuse from occurring.</p> <p>3. Per the facility's internal investigation dated 5/14/13, Resident #1 was seen by a facility nurse walking down the hallway, saw through a partially obstructed view Resident #3 started to stand up, the facility nurse indicated that he/she observed Resident #1 with his/her hands around the wrists of Resident #3 and Resident #3's hands around the wrists of Resident #1, the facility nurse yelled for a facility aide who was in the dining room. The facility LNA turned around and observed Resident #1 and Resident #3 holding each others wrists and rocking back and forth and than the LNA observed Resident #1 fall to the ground.</p> <p>Per review of the medical record Resident #3 was admitted to the facility on 2/4/13 and had diagnosis that included dementia with behavioral disturbances.</p> <p>Per review of the comprehensive behavior care plan for Resident #1, the care plan indicates that Resident #1 was to "be removed from environment when Resident #1 is invading other residents space, (dated 3/16/13), "identify behavior triggers and reduce exposure to them (dated 3/16/13), "closely monitor resident when near other residents for signs of aggression and separate residents immediately if detected. (dated 4/4/13). Per review of the medical record there was no evidence that the facility staff</p>	F 282			

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F 282	<p>Continued From page 9</p> <p>utilized any of the interventions listed on the care plan to assist Resident #1 with his/her potential issues and prevent reoccurrence.</p> <p>Per the DNS and UM confirmed in interview on 7/9/13, after reviewing the comprehensive care plan and medical record of Resident #1, they confirmed that there was no evidence that staff had utilized the interventions on the care plan for Resident #1. Specifically, that, Resident #1 was to "be removed from environment when Resident #1 is invading other residents space, (dated 3/16/13), "identify behavior triggers and reduce exposure to them (dated 3/16/13), "closely monitor resident when near other residents for signs of aggression and separate residents immediately if detected. (dated 4/4/13).</p> <p>Per review of the medical record and facility internal investigation the DNS and UM confirmed that the facility staff in there statements regarding the 5/14/13 incident that the nurse had an obstructed view of the residents and that the LNA at the time of occurrence had his/her back to Resident #1 and #2.</p> <p>Per interview with the DNS and UM, on 7/9/13, they confirmed that the facility failed to implement care plan interventions specific to the needs of Resident #1 to help reduce and prevent abuse from occurring.</p> <p>4. Per review of the facilities internal investigation dated 4/22/13, it indicated that on 4/22/13 Resident #1 was in the dining room passing out clothing protectors. Resident #1 attempted to give Resident #3 a clothing protector</p>	F 282			

*Accepted
8/5/13
[Signature]*

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F 282	<p>Continued From page 10 and when Resident #3 refused to take it, Resident #1 hit Resident #3 across the face with the clothing protectors.</p> <p>Per review of the medical record, Resident #3 was admitted to the facility on 2/4/13 with diagnosis that include dementia with behavioral disturbances.</p> <p>Per review of the medical record there was no evidence that the facility utilized care plan interventions to prevent the incident between Resident #1 and #3 on 4/22/13.</p> <p>Per review of the comprehensive behavior care plan for Resident #1, the care plan indicates that Resident #1 was to be provided a quite dining area (dated 1/25/13), "be removed from environment when Resident #1 is invading other residents space, (dated 3/16/13), "identify behavior triggers and reduce exposure to them (dated 3/16/13), "closely monitor resident when near other residents for signs of aggression and separate residents immediately if detected. (dated 4/4/13). Per review of the medical record there was no evidence that the facility staff utilized any of the interventions listed on the care plan to assist Resident #1 with his/her potential issues and prevent reoccurrence.</p> <p>The DNS and UM confirmed in interview on 7/9/13 after reviewing the comprehensive care plan and medical record of Resident #1 that there was no evidence that staff had utilized any of the care plan interventions for Resident #1, "providing a quite dining area" (dated 1/25/13), "be removed from environment when Resident #1 is invading other residents space, (dated</p>	F 282			

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

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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 07/09/2013
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 282	Continued From page 11 3/16/13), "identify behavior triggers and reduce exposure to them (dated 3/16/13), "closely monitor resident when near other residents for signs of aggression and separate residents immediately if detected. (dated 4/4/13).	F 282			