

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 21, 2013

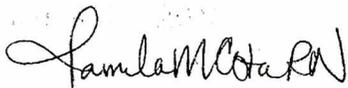
Ms. Chad Dingman, Administrator
Rutland Healthcare And Rehabilitation Center
46 Nichols Street
Rutland, VT 05701-3275

Dear Ms. Dingman:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 24, 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



AUG 19 13

PRINTED: 08/05/2013
Licensing and FORM APPROVED
Protection OMB NO. 0938-0391

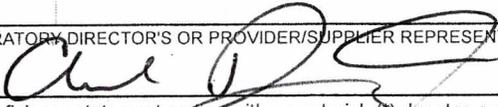
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 07/24/2013
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 An unannounced on-site recertification survey was conducted by the Division of Licensing and Protection from 7/21/13 to 7/24/13. There were regulatory deficiencies identified. The findings include:	F 000	We submit this Plan of Correction (POC) in accordance with specific regulatory requirements. It should not be construed as an admission of any deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey at any time the Provider determines that the disputed findings (1) are relied upon to adversely influence or serve as a basis in any way, for the selection and/or imposition of future remedies, whether such remedies are imposed by CMS, the State of Vermont, or any other entity, or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to facility policy or procedure should be considered to be subsequent remedial measures as that concept is employed in rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceedings on that basis.	
F 282 SS=D	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 provide services in accordance with the plan of care for 2 of 24 Stage 2 sampled residents [Resident #112 and Resident #35]. Findings include: 1. Per 7/24/13 medical record review, Resident #112 has a diagnosis of Diabetes, type 2 and is insulin dependent. His/her physician orders call for testing his/her blood sugar level 4 times per day prior to meals and before bedtime. Based on the blood sugar result, the resident is given an additional amount of Novolog insulin, (determined by a sliding scale), that is added to his/her prescribed dose of insulin at meal times. Per record review, the resident's 3/13/13 care plan for diabetes lists that staff are to "Assess and record blood glucose levels." Per 7/24/13 review of the "Glucose monitoring sheet" and Medication Administration Record	F 282	F Tag 282 Correction: Resident # 112 MAR and Glucose Monitoring sheets reviewed and corrected if the information was accessible. Resident # 35 MAR corrected and updated orders obtained.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Administrator 8/15/13

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.

Pma

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F 282	<p>Continued From page 1</p> <p>(MAR), on 7/3 (at 4PM), 7/11 (at 4 PM), 7/15 (at 7 AM and 11 AM) and on, 7/16/13 (at 4 PM), the result of the blood glucose test was not recorded. On 7/4, 7/5, 7/6 and 7/7/13, the 8 PM blood sugar results entered on the Glucose monitoring sheet differed from those entered on the MAR. On 7/9 at noon, 7/11 at noon and 5 PM, 7/12 at noon, 7/13 at noon, 7/14 at noon, 7/15 at 8 AM and noon, 7/16 at noon and 5 PM, 7/22 at 5 PM, the amount of Novolog given per sliding scale was not recorded or the entry was illegible. On 7/24/13 the unit manager confirmed that Resident #112's care plan called for the blood sugar results to be recorded and confirmed that there was missing and illegible documentation on both the Glucose monitoring sheet and the MAR. A corporate affiliate confirmed there was a documentation issue.</p> <p>On 7/24/13, two of the staff nurses who cared for Resident #112 were called in to the facility to make late entry corrections to the MAR and glucose monitoring sheet. Per 7/24/13 1:00 PM interview: when one of the nurses was asked how she could remember the correct entries, he/she responded that if he/she did not record the blood sugar result, he/she did not make a late entry for the dose of insulin given as he/she could not remember it, but he/she made late entries for the dose of insulin given (per sliding scale) when the blood sugar result was documented. The second nurse reported that she made 1 late entry prior to the 1 PM interview and was responsible for some of the illegible entries. He/she agreed that he/she did not follow the plan of care and record blood glucose results consistently.</p> <p>2. Per 7/24/13 medical record review, Resident #35 has a history of constipation and is on a</p>	F 282	<p>F Tag 282 Continued</p> <p>Identify Other Potential Residents: Residents throughout the facility have the potential to be affected by the alleged deficient practice.</p> <p>Systemic Changes: Licensed Center staff will receive re-education on policy and procedure for medication administration and documentation.</p> <p>Monitoring: DNS or designee will conduct weekly audits x 3 months on Resident MARs to ensure medication administration, interventions and documentation is legible and in compliance with results to be reviewed at QA meeting for further evaluation and recommendations.</p> <p>Responsibility: Director of Nurses</p> <p>Completion date: 8/18/2013</p> <p><i>F282 POC accepted 8/19/13 Maulhan RN / PNC</i></p>

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F 282	Continued From page 2 bowel protocol. He/she takes Fiber-con tablets (1) twice daily, Senna 8.6mg (3) tablets twice daily and Mineral oil 30 ml every day on an empty stomach. Per physician orders, if there is no BM (bowel movement) on day 3, the resident is to be given 30 ml of Milk of Magnesia. If there is no BM on day 4, the resident is to be given a dulcolax suppository between 2-4 AM and if still no BM, to be given a fleets enema. If no results by the end of the 4th day, the physician is to be called. Per medical record review, Resident #35's 9/3/12 care plan details that staff are to "Provide bowel regimen, utilize pharmacological agents as appropriate, i.e. stool softeners, laxative, etc, document effectiveness." Per 7/24/13 review of the Medication Administration Record (MAR) for 7/1/13-7/24/13, there is no documentation that Resident #35 was offered or given Milk of Magnesia as called for on day 3 of the bowel protocol. His/her record documents him/her as having received the day 4 protocol, a dulcolax suppository on 4 occasions (7/1, 7/6, 7/11 and 7/21/13). Per 7/24/13 1:56 PM interview with the resident's staff nurse, he/she reported that he/she did not document offering the resident Milk of Magnesia or document the resident's refusals to take it. The nurse was then instructed by the unit manager to make late entries in the MAR. On 7/24/13 at 2:30 PM, the unit manager agreed that there was not documentation that the care plan was followed related to the bowel regimen and use of Milk of Magnesia.	F 282			
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each	F 514			

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F 514	Continued From page 3 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 provide complete documentation and failed to assure information in the clinical record was readily accessible and accurate for 2 of 24 Stage 2 sampled residents [Resident #112 and Resident #35]. Findings include: 1. Per 7/24/13 medical record review, Resident #112 has a diagnosis of Diabetes, type 2 and is insulin dependent. His/her physician orders call for testing his/her blood sugar level 4 times per day prior to meals and before bedtime. Based on the blood sugar result, the resident is given an additional amount of Novolog insulin, (determined by a sliding scale), that is added to his prescribed dose of insulin at meal times. Per 7/24/13 review of the "Glucose monitoring sheet" and Medication Administration Record (MAR), on 7/3 (at 4 PM), 7/11 (at 4 PM), 7/15 (at 7 AM and 11 AM) and on, 7/16/13 (at 4 PM), the result of the blood glucose test was not recorded. On 7/4, 7/5, 7/6 and 7/7/13, the 8 PM blood sugar results entered on the Glucose monitoring sheet	F 514	F Tag 514 Correction: Resident # 112 MAR and care plan reviewed for accuracy. Resident # 35 MAR and orders reviewed and updated. Identify Other Potential Residents: Residents throughout the facility 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 medication administration, care plan interventions and documentation. Monitoring: DNS or designee will conduct weekly audits x 3 months to ensure medication administration, interventions and documentation are appropriate with the plan of care and in compliance with results to be reviewed at QA meeting for further evaluation and recommendations Responsibility: Director of Nurses Date of Compliance: 8/18/2013 <i>F514 POC accepted 8/19/13 McLuhannan / pmc</i>		

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F 514	<p>Continued From page 4</p> <p>differed from those entered on the MAR. On 7/9 at noon, 7/11 at noon and 5 PM, 7/12 at noon, 7/13 at noon, 7/14 at noon, 7/15 at 8 AM and noon, 7/16 at noon and 5 PM, 7/22 at 5 PM, the amount of Novolog given per sliding scale was not recorded or illegible. On 7/24/13 the unit manager confirmed that Resident #112's care plan called for the blood sugar results to be recorded and confirmed that there was missing and illegible documentation on both the Glucose monitoring sheet and the MAR. A corporate affiliate confirmed there was a documentation issue.</p> <p>On 7/24/13, two of the staff nurses who cared for Resident #112 were called in to the facility to make late entry corrections to the MAR and glucose monitoring sheet. Per 7/24/13 1:00 PM interview: when one of the nurses was asked how she could remember the correct entries, he/she responded that if he/she did not record the blood sugar result, he/she did not make a late entry for the dose of insulin given as he/she could not remember it, but he/she made late entries for the dose of insulin given (per sliding scale) when the blood sugar result was documented. The second nurse reported that she made 1 late entry prior to the 1 PM interview and reported that he/she had made illegible entries. He/she agreed that he/she did not follow the plan of care and record blood glucose results consistently.</p> <p>2. Per 7/24/13 medical record review, Resident #35 has a history of constipation and is on a bowel protocol. He/she takes Fiber-con tablets (1) twice daily, Senna 8.6 mg (3) tablets twice daily and Mineral oil 30 ml every day on an empty stomach. Per physician orders, if there is no BM (bowel movement) on day 3, the resident is to be</p>	F 514		

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F 514	Continued From page 5 given 30 ml of Milk of Magnesia. If there is no BM on day 4, the resident is to be given a dulcolax suppository between 2-4 AM and if still no BM, to be given a fleets enema. If no results by the end of the 4th day, the physician is to be called. Per 7/24/13 review of the Medication Administration Record (MAR) for 7/1/13-7/24/13, there is no documentation that Resident #35 was offered or given Milk of Magnesia as called for on day 3 of the bowel protocol. His/her record documents him/her as having received the day 4 protocol, a dulcolax suppository on 4 occasions (7/1, 7/6, 7/11 and 7/21/13). Per 7/24/13 1:56 PM interview with the resident's staff nurse, he/she reported that he/she did not document offering the resident Milk of Magnesia or document the resident's refusals to take it. The nurse was then instructed by the unit manager to make late entries in the MAR. On 7/24/13 at 2:30 PM, the unit manager agreed that there was not documentation that the care plan was followed related to the bowel regimen and use of Milk of Magnesia.	F 514		