

June 1, 2011

Mr. Timothy Urich, Administrator  
Rutland Healthcare And Rehabilitation Center  
46 Nichols Street  
Rutland, VT 05701

Dear Mr. Urich:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 5, 2011**. 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



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

RECEIVED  
Division of

PRINTED: 05/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION MAY 31 11 A. BUILDING _____ Licensing and B. WING _____ Protection	(X3) DATE SURVEY COMPLETED  <b>05/05/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET RUTLAND, VT 05701</b>
---	---

(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	<u>Plan of Correction F 253</u>	
F 253 SS=B	<p>An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection from 05/02/2011 and 05/05/2011. The following regulatory violations were identified.</p> <p><b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b></p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to maintain a clean and comfortable interior in multiple bathrooms and for one emergency cart on the third floor unit. Findings include:</p> <p>1. During the environmental tour of the third floor unit on 5/5/11 between 8:45 AM and 9:00 AM, the following observations were made:</p> <p>a) in the bathroom serving room 318, wallpaper was torn away from the wall near the baseboard heat unit, and the floor had a soiled wax buildup;</p> <p>b) in the shared bath for rooms 319 &amp; 320, there was water damage around an old flush device near the commode;</p> <p>c) in the bathroom serving room 322, there was one broken floor tile near the shower, and a soiled wax buildup on the floor.</p> <p>During the environmental tour of the third floor unit, on 5/5/11 from 8:45-9:00 AM, the Director of Maintenance confirmed a soiled wax buildup on the bathroom floors for rooms 318, 319-320, and</p>	F 253	<p><u>Corrective Action:</u> The wallpaper in room 318 has been repaired, the floor tiles in room 318's bathroom have been replaced, the water damage in bathroom 319/320 has been repaired, the broken floor tile in 322's bathroom was replaced and wax build-up removed. The dirt and wax build-up on the bathroom floor tiles in rooms 321/322 as well as 327/328 has been removed.</p> <p>All facility emergency carts have been inspected and cleaned to ensure proper sanitation and no expired products.</p> <p><u>Identify Other Potential Residents:</u> In order to identify other residents having the potential to be affected by the same alleged deficient practice, the following will be completed.</p> <p><u>Systemic Changes:</u> The Director of Maintenance or designee will conduct a complete audit of all bathrooms to ensure a sanitary, orderly and comfortable interior is maintained.</p> <p><u>Monitoring:</u> Audits will be completed monthly X4 by the Maintenance Director or designee. The results of these audits will be reported by the Director of Nurses to CQI Committee. The CQI Committee will evaluate the data and act on the information as indicated.</p> <p><b>Responsibility:</b> Maintenance Director <b>Completion Date:</b> 6/27/2011</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>ADMINISTRATOR</b>	(X6) DATE <b>5/26/11</b>
--	-------------------------------	-----------------------------

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.

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

PRINTED: 05/18/2011  
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  05/05/2011
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 253	Continued From page 1 322. Additionally s/he confirmed torn wallpaper near the baseboard heat unit in room 318's bath, water damage around an old flush device in the bath for 319-320, and a broken floor tile near the shower for room 322.  2. Per observation during the initial tour of the 3rd floor unit, on the morning of 5/2/11, a cart with emergency supplies located on 3 North was noted to have dust covered shelves, back board, open airway and other equipment, and expired sterile saline solution (3 bottles). Per interview on 5/5/11 at 12:25 PM, the Unit Manager confirmed that the cart was soiled and had expired items. S/he stated that the night shift was responsible for checking the cart nightly.  3. During initial tour of the third floor, on the morning of 5/2/11, the floors of the bathrooms that were shared between rooms 321 and 322 as well as 327 and 328, were observed to have dirt and wax buildup around the baseboard areas. Per interview, conducted on 5/2/11, the housekeeper confirmed that there did appear to be dirt and wax build up along the edges.	F 253	<i>F253 POC Accepted 5/31/11 G. Coleman RN / J. McCarty RN</i>	
F 279 SS-D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279	<u>Plan of Correction F 279</u>  <u>Corrective Action:</u> Resident #62 has a careplan for psychoactive medications. Resident #32 has an activities careplan Resident #55 has a careplan addressing psychosocial needs  <u>Identify Other Potential Residents:</u> In order to identify other residents having the potential to be affected by the same alleged deficient	

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

PRINTED: 05/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/05/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET RUTLAND, VT 05701</b>	
(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 279	<p>Continued From page 2 needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop comprehensive care plans with measurable goals and specific interventions to meet the medical and psychological/social needs for 3 of 17 residents in the stage 2 sample. (Residents # 32, # 55 and # 62) Findings include:</p> <ol style="list-style-type: none"> <li>Per record review on 5/3/11, and confirmed during interview with the RN (Registered Nurse) Unit Manager at 4:40 PM, Resident #62 received psychoactive medications for management of depression and anxiety disorders and there was no care plan developed to address these needs.</li> <li>Per record review, conducted on 5/3/11, the care plan for Resident #32 did not address the activity interests identified during the initial comprehensive assessment completed on 1/12/11. Although the assessment, completed by the Activities Director (AD), stated that Activities would be addressed in the resident's care plan,</li> </ol>	F 279	<p><i>F 279 Cont.</i></p> <p>practice, the following will be completed.</p> <p><u>Systemic Changes:</u> The Unit Manager or designee will audit residents that have psychoactive medications to ensure they have a careplan in place if indicated.</p> <p>The Activities Director or designee will audit residents to ensure they have an activities careplan if indicated.</p> <p>The Social Service Director or designee will audit residents to ensure that careplans are in place addressing psychosocial needs if indicated.</p> <p>The NPE or designee will educate nursing staff on initiating careplans for psychoactive medications. The NPE or designee will educate the Activities and Social Service Director on initiating careplans.</p> <p><u>Monitoring:</u> Audits will be completed monthly X4 by the Unit Managers, Activities and Social Service Director or designee. The results of these audits will be reported by the Director of Nurses to CQI Committee. The CQI Committee will evaluate the data and act on the information as indicated.</p> <p><u>Responsibility:</u> Director of Nursing Completion Date: 6/27/2011 <i>F279 POC Accepted 5/31/11 G.Coleman RN J. McArthur</i></p>	

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

PRINTED: 05/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/05/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET RUTLAND, VT 05701</b>	
(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 279	Continued From page 3 the care plan had not been completed as of 5/4/11. This was confirmed by the AD at the time of interview, who stated that it was his/her responsibility to complete the care plan. The DNS (Director of Nursing Services) confirmed, during interview on the morning of 5/5/11, that it was the AD's responsibility to complete the Activities care plan.  3. Per record review on 5/5/11, Resident #55 had lived at the facility before the resident's spouse was admitted with a terminal illness. The spouse died on 9/3/10 after continued decline from illness. Per review of the resident's plan of care, there was no plan developed to address the psychosocial needs related to grief and loss experienced by the resident. Per interview on 5/5/11 at 8:08 AM, the Social Services Director confirmed that psychosocial issues were identified for this resident, however a plan to address the specific needs of the resident related to grief and loss was not developed for this resident.	F 279		
F 280 SS=D	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	F 280	<u>Plan of Correction</u> <b>F 280</b>  <u>Corrective Action:</u> Resident #29's ADL careplan and C.N.A Kardex have been updated to indicate the resident's current status. Resident #134's nutrition careplan has been updated to indicate the resident's current status.  <u>Identify Other Potential Residents:</u> In order to identify other residents having the potential to be affected by the same alleged deficient practice, the following will be completed.	

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

PRINTED: 05/18/2011  
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  05/05/2011
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 280	<p>Continued From page 4</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, the facility failed to to revise the care plan to address the resident's current needs regarding functional or nutritional status for 2 of 17 residents in the stage 2 sample. (Resident #29 &amp; #134) Findings include:</p> <p>1. Per record review on 05/04/2011 at 9:17 AM, there are physician orders that Resident #29 is to stand-pivot as part of a therapy program that was initiated after a fall on 04/03/2011 that resulted in a fractured left ankle. The comprehensive care plan and the Kardex that is used by the LNAs for delivery of care both indicate that this resident is to ambulate with 1 assist, a walker and gait belt.</p> <p>Per interview with staff on 05/04/2011 at 11:00 AM s/he indicated that care plans are a working tool and are updated by any one of the staff when changes occur. Staff further confirms that the current care plan is not reflective of the resident's actual ambulation status since the fall on 04/03/2011. The care plan and Kardex both indicate that resident is ambulating with assist and walker. Since the fall on 04/03/2011, the resident's mobility has been limited to stand-pivot.</p>	F 280	<p><i>F 280 Cont.</i></p> <p><u>Systemic Changes:</u> The Unit Manager or designee will audit ADL careplans and Nutrition Careplans to ensure that the resident's current status is indicated.</p> <p>The NPE or designee will educate all nursing staff, and the dietician on updating and revising careplans.</p> <p><u>Monitoring:</u> Audits will be completed by the Unit Manager and Dietician or designee monthly X4. The results of these audits will be reported by the Director of Nurses to CQI Committee. The CQI committee will evaluate the data and act on the information as indicated.</p> <p><u>Responsibility:</u> Director of Nursing <u>Completion Date:</u> 6/27/2011</p> <p><i>FABO POC Accepted 5/31/11 G. Coleman RN / AMcotarn</i></p>		

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

PRINTED: 05/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/05/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET RUTLAND, VT 05701</b>	
(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 280	<p>Continued From page 5</p> <p>Per interview with Resident #29 at 11:41 AM, s/he reports going to therapy since the fall on 04/03/2011, and that walking will not happen for at least another week.</p> <p>An updated care plan is not available and the current one has not been changed to reflect a fall in April. There is also no change in ambulation status on the current care plan. This is confirmed during interview with staff on 05/04/2011 at 11:08 AM. Per interview with LNAs on 05/05/2011 at 11:35 AM who provide care to Resident #29 they report that staff know to not walk this resident via morning meeting reports, and usually with the Kardex, which they confirm has not been updated.</p> <p>2. Per record review on 5/3/11, the care plan for nutritional risk for Resident #134 was not revised to reflect current needs/status after the interdisciplinary care plan meeting on 4/28/11. During the period from 1/15/11 to 5/2/11, the resident lost 8.4 % of body weight (from 153 lbs. to 140 lbs.). The 3/24/11 care plan goal to consume =&gt; 75% at most meals was not met (per review of intake sheets) and there was no evidence of re-evaluation of this goal. Review of the weight summary for this resident revealed that the resident is on weekly weights. The care plan intervention for weighing the resident stated "weigh monthly and PRN". Per telephone interview with the RD [Registered Dietician], who is responsible for the nutritional care plan, on 5/3/11 at 11:05 AM, s/he confirmed that the resident is being weighed weekly and that the care plan is not current. During interview on 5/3/11 at 10:15 AM, the Nurse Manager stated that the resident prefers to drink Diet Pepsi</p>	F 280		

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

PRINTED: 05/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/05/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET RUTLAND, VT 05701</b>	
(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 280	Continued From page 6 (brought in by the spouse) and take medications with pudding. This was not included on the current care plan. The care plan stated "encourage 100% consumption of all fluids provided."	F 280		
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 staff interview and record review, the facility failed to assure that staff provided care in accordance with the written plan of care regarding nutrition and/or hydration status for 3 of 17 residents in the stage 2 sample. (Residents #32, 62 and 134) Findings include:  1. Per record review on 5/3/11, Resident #134's care plan intervention to "offer snacks" was not consistently implemented. The resident had experienced a weight loss of 8.4% since readmission on 1/15/11 (from 153 lbs on 1/15/11 to 140 lbs. on 5/2/11). During interview on 5/3/11 at 10:15 AM, the RN Unit Manager confirmed that the LNAs should be documenting on the Food Intake Sheets the snacks offered and consumed by the resident (each AM, PM and HS [hour of sleep]). Review of the sheets for January through March reveal that snacks (for HS only) were documented as given only on 4 dates (2/1/11, 2/5/11, 3/23/11 and 3/24/11). On 4/21/11, the resident moved to a different floor and HS snacks	F 282	<u>Plan of Correction</u> <b>F 282</b>  <u>Corrective Action:</u> Resident #134 is currently stable and snacks are being offered and documented consistently. Resident #62 is currently stable and snacks are consistently being offered and documented consistently. Resident #32 is currently stable and fluids are consistently being offered and documented consistently.  <u>Identify Other Potential Residents:</u> In order to identify other residents having the potential to be affected by the same alleged deficient practice, the following will be completed.  <u>Systemic Changes:</u> The NPE or designee will educate the L.N.A staff on policy of offering and documentation of snacks and fluids. The Unit Managers or designee will audit snack and offering fluids by L.N.A staff and the documentation of the food intake records to ensure compliance and accuracy.  <u>Monitoring:</u> Audits will be completed by the Unit Managers or designee monthly X4. The results of these audits will be reported by the Director of Nurses to CQI Committee. The CQI committee will	

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

PRINTED: 05/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/05/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET RUTLAND, VT 05701</b>		
(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 282	<p>Continued From page 7</p> <p>were documented as consumed on all dates except 4/30/11. The morning (AM) and afternoon (PM) snacks were all documented as "N" which means "not offered" per the key on the sheet instructions box. During interviews with day and evening shift LNAs on 5/3/11, they stated they did not always have time to offer snacks and may have miscoded some days if the resident was asleep or refused and did not get a snack. This lack of documentation was also confirmed during interviews the Unit Managers on 5/3/11 and 5/4/11 and via telephone call with the RD [Registered Dietician] on 5/3/11 at 11:05 AM.</p> <p>2. Per record review on 5/4/11, nursing staff failed to consistently provide and/or document "snacks" offered and monitor all meal intakes, as stated in the care plan for Resident #62. The resident was identified as being at nutritional risk and had experienced a weight loss of 12 lbs. from 3/29/11 to 5/1/11 (117 lbs to 105 lbs). Review of the Food Intake Sheets for April showed no documentation of snacks offered from 4/2/11 - 4/11/11 except for 1 HS (bedtime) snack on 4/3/11. From 4/11/11 to 4/30/11, only HS snacks were documented as consumed; AM and PM snacks were all documented as "N", not offered. In addition, there were no meal intakes recorded for 4/7/11 and 4/9/11 for the noon meal and 4/30/11 for the evening meal. The LNAs failure to document all meals and provision of snacks consistently, per the care plan, was confirmed during interviews with 2 LNAs (as stated above) and the Nurse Managers of the 1st floor and 3rd floors on the mornings of 5/3/11 and 5/4/11.</p> <p>3. Per record review staff failed to consistently offer or encourage fluids in accordance with the care plan for Resident #32, who had been</p>	F 282	<p><i>F 282 Cont.</i></p> <p>evaluate the data and act on the information as indicated.</p> <p><b>Responsibility: Director of Nursing</b> <b>Completion Date: 6/27/2011</b></p> <p><i>F282 POC Accepted 5/31/11</i> <i>G. Coleman RN / CPMcotARN</i></p>		

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

PRINTED: 05/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/05/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET RUTLAND, VT 05701</b>	
(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 282	Continued From page 8 identified as at risk for dehydration. The current care plan, initiated on 1/14/11, directed staff to; "encourage resident to consume all fluids during meals" and "offer/encourage fluids of choice". Per resident interview, at 1:10 PM on 5/2/11 and again in the afternoon of 5/3/11, Resident #32 stated that staff did not routinely offer fluids between meals and if they did s/he would accept them. The resident further stated s/he was frequently encouraged by family and doctor to drink plenty of fluids to prevent dehydration and s/he would get his/her own water to drink from the bathroom faucet. Review of the food intake records revealed documentation of an "N" (key = "not offered") in the space utilized for between meal fluids on 162 out of 163 opportunities between 1/1/11 through 3/31/11, and on 5 out of 10 opportunities for the month of May 2011.  During interview, on 5/3/11, LNA #1, who had been responsible for providing care at times over the past 4 months to Resident #32, stated that, although s/he had some misunderstanding of how to accurately document fluid intake on the food intake form, s/he did not offer fluids between meals on a consistent basis in accordance with the care plan. The LNA stated that there was not always enough time to offer fluids between meals to all residents. The Unit Nurse Manager confirmed, during interview on the afternoon of 5/3/11, the Food Intake Form was to be utilized by staff to record how much fluid residents receive. S/he further agreed documentation on the forms used during the months between January 2011 and current date, could be interpreted as failure of staff to offer fluids to the resident.	F 282		
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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

PRINTED: 05/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/05/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET RUTLAND, VT 05701</b>	
(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=B	<p>Continued From page 9</p> <p><b>LABEL/STORE DRUGS &amp; BIOLOGICALS</b></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:</p>	F 431	<p><b>Plan of Correction F 431</b></p> <p><u>Corrective Action:</u> The vial of regular insulin was discarded on 5/2/11. The Promethazine 25 mg suppositories were discarded on 5/2/11.</p> <p><u>Identify Other Potential Residents:</u> In order to identify other residents having the potential to be affected by the same alleged deficient practice, the following will be completed.</p> <p><u>Systemic Changes:</u> The NPE or designee will educate all nursing staff on storage of drugs and biologicals and labeling of medications. The Unit Managers or designee will audit the medication storage room refrigerators for unlabeled and expired medications.</p> <p><u>Monitoring:</u> Audits will be completed by the Unit Managers or designee monthly X4. The results of these audits will be reported by the Director of Nurses to CQI Committee. The CQI committee will evaluate the data and act on the information as indicated.</p> <p><b>Responsibility:</b> Director of Nursing <b>Completion Date:</b> 6/27/2011</p> <p>F431 POC Accepted 5/31/11 G. Coleman RN / J. McArthur RN</p>	

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

PRINTED: 05/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/05/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET RUTLAND, VT 05701</b>	
(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	Continued From page 10 Based on observation and staff interview, the facility failed to assure that all drugs and biologicals were within the expiration date or labeled properly. Findings include:  Per observation on 5/2/11 at 4:10 PM, the medication refrigerator located in the medication storage room on the first floor contained unlabeled or expired medications. There was a vial of regular insulin that was opened, but not labeled with the date it was opened. There were 37 suppositories of Promethazine 25 mg. [milligrams] with an expiration date of 2/2011, and 4 suppositories of Prochlorperazine 25 mg. with an expiration date of 10/2010. Per interview on 5/2/11 at 4:30 PM, the Unit Manager confirmed that the insulin was not labeled with the date it was opened, and that the suppositories listed above were beyond the expiration date.	F 431		
F 441 SS=D	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	<b><u>Plan of Correction</u></b> <b>F 441</b>  <u>Corrective Action:</u> Resident #98 is currently stable and is receiving sandwiches on a plate. L.N.A was reeducated on infection control policy and practice.  <u>Identify Other Potential Residents:</u> In order to identify other residents having the potential to be affected by the same alleged deficient practice, the following will be completed  <u>Systemic Changes:</u> The NPE will educate all nursing staff on infection control practice and safe handling of food. The Unit Managers or designee will audit meals to ensure that proper food handling	

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

PRINTED: 05/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/05/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET RUTLAND, VT 05701</b>	
(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 441	<p>Continued From page 11</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that staff washed hands and/or donned gloves when indicated during meal assistance for 1 applicable resident during a meal observation during the survey. (Resident # 98) Findings include:  Per observation of meal assistance for Resident #98 on 5/2/11 at 12:15 PM in the 2 North dining room, the LNA removed a sandwich from the meal cart and proceeded to remove the sandwich from the bag with bare hands and placed it on the table (on top of the bag) in front of the resident. Prior to handling the sandwich, the LNA failed to cleanse hands and/or don gloves. The lack of</p>	F 441	<p><i>F 441 Cont.</i></p> <p>and infection control practice is in compliance.</p> <p><u>Monitoring:</u> Audits will be completed by the Unit Managers or designee monthly X4. The results of these audits will be reported by the Director of Nurses to CQI Committee. The CQI committee will evaluate the data and act on the information as indicated.</p> <p><u>Responsibility:</u> Director of Nursing <u>Completion Date:</u> 6/27/2011</p> <p><i>F441 POC Accepted 5/31/11 G. Coleman RN / D. MONTARN</i></p>	

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

PRINTED: 05/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/05/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET RUTLAND, VT 05701</b>
---	---

(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 441	Continued From page 12 hand cleansing was confirmed with the LNA after the observation.	F 441		
-------	--	-------	--	--

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NDfs	PROVIDER # <b>475039</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>5/5/2011</b>
NAME OF PROVIDER OR SUPPLIER <b>RUTLAND HEALTHCARE AND REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET RUTLAND, VT</b>		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 514</b>	<p><b>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</b></p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and confirmed through staff interview, the facility failed to assure that documentation was accurate in one resident record (Resident #55). Findings include:</p> <p>Per record review on 5/4/11, Resident #55 had monthly pharmacy reviews in the active medical record that were labeled with the incorrect resident name and birth date, and instead had the name and birth date of the Resident's spouse, who had died on September 3, 2010. Per review of the medications and labs addressed in the monthly reviews since September 2010, the Pharmacy reviews were consistent with the medical record of Resident #55. Per interview on 5/4/11 at 9:45 AM, the Unit Manager confirmed that the spouse listed on the Pharmacy Review sheet had been deceased since September 2010, and that the reviews since that time matched the medical record of Resident #55. Per interview on 5/4/11 at 12:05, the Pharmacist was interviewed by telephone and confirmed that the name and birth date on the review sheet was incorrect, however was the pharmacy review of Resident #55, and that they would come to the facility to correct the documentation.</p> <p><b><u>Plan of Correction</u> F 514</b></p> <p><b><u>Corrective Action:</u></b> Resident #55's monthly pharmacy review sheet has been corrected and replaced in the residents chart.</p> <p><b><u>Identify Other Potential Residents:</u></b> In order to identify other residents having the potential to be affected by the same alleged deficient practice, the following will be completed. The NPE or designee will educate the pharmacy consultant on using correct names and birth date of residents on the pharmacy review sheet.</p> <p><b><u>Systemic Changes:</u></b> The Medical Records person or designee will audit the pharmacy review sheets to ensure accurate names and dates of births are indicated.</p> <p><b><u>Monitoring:</u></b> Audits will be completed monthly X4 by the Medical Records person or designee. The results of these audits will be reported by the Director of Nurses to CQI Committee. The CQI committee will evaluate the data and act on the information as indicated.</p> <p><b>Responsibility:</b> Director of Nursing <b>Completion Date:</b> 6/27/2011</p> <p style="text-align: right;"><i>FS14 POC Accepted 5/31/11 G. Coleman / CPM</i></p>		

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