

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/71-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

February 29, 2012

Ms. Diane Sullivan, Administrator
The Pines At Rutland Center For Nursing And Rehab
99 Allen Street
Rutland, VT 05701

Dear Ms. Sullivan:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 8, 2012**. 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, MS
Licensing Chief

PC:jl



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

RECEIVED
Division of
PRINTED: 02/15/2012
FORM APPROVED
FEB 24 12
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED 02/08/2012
NAME OF PROVIDER OR SUPPLIER THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI			STREET ADDRESS, CITY, STATE, ZIP CODE 99 ALLEN STREET RUTLAND, VT 05701		
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F 000	INITIAL COMMENTS	F 000			
F 280 SS=D	<p>An unannounced on-site recertification survey was conducted by the Division of Licensing and Protection on 02/06/12 - 02/08/12. The following are regulatory findings.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to review and revise the Care Plan for 1 of 8 residents in the sample group. (Resident #124) Finding include;</p> <p>1. The care plan for Resident #124 has not been</p>	F 280	<p>This plan of correction is the facility's credible allegation of compliance. The filing of this plan does not constitute an admission that the deficiencies alleged did in fact exist. This plan of correction is filed and executed as evidence of the facility's desire to comply with the provisions of federal and state law, and to continue to provide quality care and services.</p> <p>F280 Right to Participate Planning Care – Revise CP Comprehensive care plans are developed for all residents of the facility, with participation of the residents, and reviewed and revised periodically. The care plan for Resident #124 has been reviewed and revised to reflect the resident's current social concerns and needs. Resident care plans were reviewed, by RN Nurse Managers and RN Nurse Assessors, in order to ensure that resident care plans had been reviewed timely and revised to reflect current needs. The Activity Director reviewed resident care plans to ensure that residents' social concerns and needs were addressed timely. RN Nurse Assessors and RN Nurse</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Nancy Sullivan Administrator 2/21/12

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.

SMC

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F 280	Continued From page 1 revised to reflect social concerns and needs. Per review of the Activity care plan dated 10/18/11, it states 'goals met except does not want to participate out side room - does have company and loves her TV and computer'. The interventions state ' provide in-room activities to promote mental stimulation and added socialization' and '[s/he] also goes to 2nd floor to see spouse'. However, the resident's computer went missing in November 2011 and the spouse no longer lives in the building. The quarterly care plan meeting for January 2012 was not held. Per interview at 3:45 PM on 2/7/12, the MDS coordinator confirmed the quarterly care plan meeting was not held and the care plan has not been revised to show changes in the activities.	F 280	Managers will complete a double check of the monthly care plan list, to include a tracking system for all quarterly care plan reviews. The Activity Director has been provided with re-education related to timely revisions of the care plan, by the Administrator. Monthly audits of 20% of resident care plans will be completed by the DNS, and/or her designee, and the Activity Director, in order to ensure that care plans are reviewed and revised on a timely basis. Audit findings will be reported to the Quality Assurance Committee monthly, and will be reviewed and monitored by the Administrator.		
F 281 SS=D	Also see F276. 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 interview and record review, the facility failed to administer medication per physician order for 1 of 22 residents in the applicable stage 2 sample (Resident #189). Findings include: Per record review on 2/7/12 at 3:02 PM, staff failed to follow a physician order to administer a medication for Resident #189. On 1/31/12, the physician ordered Trazadone (an anti-depressant) 25 milligrams (mg) by mouth every noon, increase to 50 mg if no improvement	F 281	Completion Date: 3/8/12 <i>F280 POC accepted 2/21/12 [signature]</i> F281 Services Meet Professional Standards The services provided by the facility continue to meet professional standards of quality. Resident #189's physician order for Trazadone has been clarified and medication is being as directed by the physician order. Resident physician orders and MAR's were reviewed by the DNS and her designees in order to ensure that medication is being administered per physician order. Nursing staff was provided with education related to following		

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F 281	Continued From page 2 in 7 days. On 2/5/12, the physician ordered Trazadone 50 mg by mouth every hour of sleep (HS). Per record review, there is a physician order dated 2/6/12 for Trazadone 50 mg by mouth every noon and HS. Per review of the Medication Administration Record (MAR), staff discontinued the noon dose of the Trazadone on 2/5/11. There is no physician order to discontinue the 1200 noon dose of Trazadone. Per review of the MAR, the last 1200 noon dose was given on 2/4/12. 3 doses were not administered per physician's order. Per interview on 2/7/12 at 3:35 PM, the Unit Manager (UM) stated h/she assumed the physician meant to discontinue the noon order and change to HS. The UM confirmed there is no physician order to discontinue the noon dose and that 3 doses were not administered per the physician order.	F 281	physician orders, clarifying physician orders when necessary, and administering medication per physician orders, by the Staff Development Coordinator and Director of Nursing. Monthly audits of physician orders and respective medication records will be preformed by the DNS, and/or her designee, on 20% of resident records, in order to ensure continued compliance with physician orders. Audit results will be reported to the Quality Assurance Committee monthly, and will be reviewed and monitored by the Administrator. Completion Date: 3/8/12	
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 assure that services were provided according to the resident's written plan of care regarding monitoring effects of medications for 1 of 22 residents in the Stage 2 sample. (Resident #148) Findings include: 1. Per review of the clinical record for Resident #148, who was receiving the psychotropic	F 282	<i>F281 POA accepted 2/20/12 Simmons RN / Pivetti RN</i> F282 Services by Qualified Persons/Per Care Plan Residents' services continue to be provided by qualified persons and in accordance with each resident's plan of care. Following the administration of Ativan to Resident #148, the nursing staff have documented their observations related to the effectiveness of the medication on the MAR. A review of the medication records was performed by the RN Nurse Managers in order to ensure that nursing staff are observing for the	

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F 282	Continued From page 3 medication Ativan (anti-anxiety), the care plan directs staff to 'observe for effectiveness of meds, encourage feelings, provide 1:1 support'. Per review of the nursing notes and the Medication Administration record (MAR), Ativan 0.5 milligrams was administered twice on 02/01/12 with staff monitoring for effects only once. In addition, Ativan was administered twice on 02/02/12 and 02/03/12 and once on February 4th, 5th, 6th, 7th, all without documentation of monitoring the effects of the medication, for a total of 9 out of 10 administrations from 02/01/12 through 02/07/12 without monitoring for effectiveness. For the month of January 2012, 21 out of 25 administrations of Ativan were given without staff monitoring the effects/response. Per interview on 02/08/12 at 10:35 AM, The Staff Development Coordinator (SDC) and the Unit Manager state they would expect that the nursing notes or MAR have documentation for response/effect or if other interventions were tried. They confirmed at this time staff did not implement the care plan.	F 282	effectiveness of the administered medications and documenting such. Nursing staff received re-education, by the Staff Development Coordinator and the DNS, regarding the need to follow the plan of care, and specifically document the effectiveness of certain medications. Monthly audits of 20% of resident medication records and the corresponding plan of care will be reviewed, by the RN Nurse Managers, in order to ensure continued compliance. Audit results will be reported to the Quality Assurance Committee monthly, and will be reviewed and monitored by the Administrator. Completion Date: 3/8/12 <i>Page POC accepted 2/26/12 Sennomon RN / P. Montanari RN</i>		
F 329 SS=D	Also see F329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	F329 Drug Regimen is free from Unnecessary Drugs Residents' drug regimens are free from unnecessary drugs. Nursing staff are documenting the medication effects of prn Ativan for Resident #148. The pharmacy recommendation for Resident #148's Ambien dose and the physician's review has been documented. Resident #32 does not receive the prn Ativan or Senokot.		

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F 329	<p>Continued From page 4</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure 3 of 10 applicable residents in the targeted stage 2 sample were free from unnecessary drugs. (Residents #148 , #32 & #72) Findings include:</p> <p>1. Per review on 02/07/12 of the clinical record, Resident #148 was receiving the short-acting benzodiazepine (anti-anxiety) medication Ativan 0.5 milligrams (mg) as needed (PRN) for increased anxiety without adequate monitoring. Per the physician order, the Ativan could be given every 6 hours. Per review of the nursing notes and the Medication Administration record (MAR) Ativan was administered twice on 02/01/12 with staff monitoring for effects only once. In addition, Ativan was administered twice on 02/02/12 and 02/03/12 and once on February 4th, 5th, 6th, and 7th, all without documentation of monitoring the effects of the medication, for a total of 9 out of 10</p>	F 329	<p>Resident #72 does not receive the discontinued prn Ativan. Physician orders for medication and medication administration records were reviewed and reconciled with pharmacy recommendations, by the RN Nurse Managers, in order to ensure accuracy.</p> <p>Re-education regarding unnecessary drugs, physician orders, pharmacy recommendations, and related documentation requirements was provided to nursing staff by the Staff Development Coordinator and Director of Nursing.</p> <p>Monthly audits of medication records and physician orders will be performed by the DNS, and/or her designee, in order to ensure continued compliance.</p> <p>Audit findings will be reported to the Quality Assurance Committee monthly, and reviewed and monitored by the Administrator.</p> <p>Completion Date: 3/8/12</p> <p><i>F329 POC accepted 2/28/12 summary R/P/AM/ctarw</i></p>		

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F 329	<p>Continued From page 5</p> <p>administrations without monitoring for effectiveness. For the month of January 2012, 21 out of 25 administrations of Ativan were given without staff monitoring the effects/response.</p> <p>In addition, for Resident #148, the pharmacist recommended in November 2011 and December 2011 that the drug Ambien, a drug used for sleep induction, be lowered from 10 mg which is "not recommended dose in elderly" to 5 mg. There was no follow up by the facility to the physician regarding the pharmacist's recommendations. Per interview on 02/08/12 at 10:35 AM, the Staff Development Coordinator (SDC) and the Unit Manager stated the expectation is that nursing will document in the nursing notes or MAR for efficacy and/or adverse consequences after the administration of Ativan. During the same interview, they stated the expectation is that the pharmacy recommendation regarding Ambien should be reviewed and acted upon. They confirmed at that time the clinical record lacks evidence of a review for the continued necessity of the dose of Ambien</p> <p>Also see F282 and F428</p> <p>2. Per record review on 2/7/11, Physician Orders for Resident #32 dated 11/8/11 read 'discontinue Ativan [a benzodiazepine medication] 0.5 milligrams by mouth every 4 hours PRN [as needed]. Discontinue Senokot [a laxative] 1 tab PRN'. Per record review, Resident #32's Medication Administration Record (MAR) for</p>	F 329			

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F 329	Continued From page 6 December 2011, January 2012, and February 2012 still contained both the Ativan PRN order and the Senokot PRN order. The MAR documents Resident #32 was given both medications as PRN doses after the Physician's Order to discontinue them; Ativan was given 2/3/12, Senokot was given 12/16/11. Per interview on 2/8/11 at 9:12 A.M., the facility's Assistant Administrator confirmed both the Ativan PRN and Senokot PRN orders were not discontinued per the Physician's Order, and both medications were administered to Resident #32 as PRN doses after the order to discontinue them. 3. Per record review on 2/8/11, Physician Orders for Resident #72 dated 11/3/11 state 'change PRN [as needed] bedtime dose of Ativan [a benzodiazepine medication] 1 milligram to every bedtime'. Per record review, Resident #72's Medication Administration Record (MAR) for December 2011, January 2012, and February 2012 still contained both the Ativan PRN order and the Ativan to be given at every bedtime order. The MAR documents Resident #72 was given both the bedtime dose and a PRN dose of Ativan on 12/3/11. Per interview on 2/8/11 at 9:12 A.M. the facility's Assistant Administrator confirmed the Ativan PRN order was not discontinued and changed to every bedtime per the Physician's Order, and the medication was administered to Resident #32 on 12/3/11 as a PRN dose after the order to discontinue it. Also see F428	F 329			
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356			

ADNS

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F 356	<p>Continued From page 7</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the required information in a prominent place readily accessible to residents and visitors. Findings include:</p>	F 356	<p>F356 Posted Nurse Staffing</p> <p>The facility continues to post nurse staffing data on a daily basis. The daily nurse staffing is posted in the lobby area and includes the resident census. Facility staff have been provided with education related to ensuring that the daily resident census is included. The Director of Nursing and Administrator will monitor for daily continued compliance, and report findings monthly to the Quality Assurance Committee. Completion date: 2/9/12</p> <p><i>F356 POC accepted 2/22/12 SEMMONS/RW/ANNOSTERN</i></p>		

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F 356	Continued From page 8 Per observation on 2/7/12 at 2:00 PM, the facility failed to post the resident census on the daily staffing posting. Additionally, the daily posting was in an area not frequented by residents or visitors. Per review of facility daily staffing postings for the past 3 months, the resident census had been omitted from the daily postings. These observations were confirmed by the Director of Nursing Services (DNS) on 2/7/12 at 2:06 PM.	F 356	F428 Drug Regimen Review Residents' drug regimens are reviewed monthly by a licensed pharmacist and irregularities are reported to the physician, and DNS, for review and response. Resident #148's pharmacy recommendations have been reviewed and responded to by the physician.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the pharmacist failed to report irregularities and/or the facility failed to act upon the consultant pharmacist's recommendations for 3 of 10 residents in the sample. (Residents #148, #32 & #72) Findings include: 1. Per record review on 02/07/12 of Resident #148's chart, of the pharmacy review dated November 2011, the pharmacist recommended "Ambien 10 mg [milligrams] not recommended	F 428	Resident #32's medication administration record has been corrected, and the pharmacy has been notified of their error and oversight of the irregularities. Resident # 72's medication administration record has been corrected, and the pharmacy has been notified of their error and oversight of the irregularity. Physician orders for medication and medication administration records were reviewed and reconciled by the RN Nurse Managers, in order to ensure accuracy. Pharmacy has been provided with feedback and re-education related to their role and responsibility related to drug regimen reviews and MAR accuracy, by the Director of Nursing and Administrator. Nursing staff have been provided	

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F 428	Continued From page 9 dose in elderly, would 5 mg be ok?" Also, the December 2011 pharmacy review states "see note 11/11/11 regarding Ambien 10 mg". The physician made a visit on 02/04/12, however there was no reply to the pharmacy recommendation. Per interview on 02/07/12 at 5:27 PM, the acting evening supervisor stated "I retired and this has been an issue, so now I'm going to start looking over the yellow copies and contacting the physician about the recommendations". S/he confirmed that recommendations have not been acted upon for 4 months. 2. Per record review on 2/7/11, Physician Orders for Resident #32 dated 11/8/11 read 'discontinue Ativan [a benzodiazepine medication] 0.5 milligrams by mouth every 4 hours PRN [as needed]. Discontinue Senokot [a laxative] 1 tab PRN'. Per record review, Resident #32's Pharmacy Medication Regimen Reviews dated November 11, 2011, December 28, 2011, and January 21, 2012 report "no irregularities". Per record review, Resident #32's Medication Administration Record (MAR) for December 2011, January 2012, and February 2012 still contained both the Ativan PRN order and the Senokot PRN order. The MAR documents Resident #32 was given both medications as PRN doses after the Physician's Order to discontinue them; Ativan was given 2/3/12, Senokot was given 12/16/11. Per interview on 2/8/11 at 9:12 A.M. the facility's Assistant Administrator confirmed both the Ativan PRN and	F 428	with re-education related to the discontinuation of medications, monthly "change over" requirements, and pharmacy recommendations, by the Staff Development Coordinator and Director of Nursing. Monthly audits of 20% of resident medication records and physician orders will be performed by the DNS, and/or her designee, in order to ensure continued compliance. Audit findings will be reported to the Quality Assurance Committee monthly, and reviewed and monitored by the Administrator. Completion Date: 3/8/12 F428 POC accepted 2/28/12 SENOKOT/Ativan PRN		

ADNS

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/08/2012
NAME OF PROVIDER OR SUPPLIER THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI			STREET ADDRESS, CITY, STATE, ZIP CODE 99 ALLEN STREET RUTLAND, VT 05701		
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F 428	<p>Continued From page 10</p> <p>Senokot PRN orders remained on Resident #32's MAR, and were not discontinued per the Physician's Order by either Nursing or Pharmacy. The Assistant Administrator stated "there was no system in place" to alert Nursing of a discontinued medication order that cannot be altered in the computer by the Pharmacy and will continue to be printed on the resident's MAR.</p> <p>3. Per record review on 2/8/11, Physician Orders for Resident #72 dated 11/3/11 state 'change PRN [as needed] bedtime dose of Ativan [a benzodiazepine medication] 1 milligram to every bedtime'. Per record review, Resident #72's Pharmacy Medication Regimen Reviews for November 2011, December 2011, and January 2012 report "no irregularities". Per record review, Resident #72's Medication Administration Record (MAR) for December 2011, January 2012, and February 2012 still contained both the Ativan PRN order and the Ativan to be given at every bedtime order. The MAR documents Resident #72 was given both the bedtime dose and a PRN dose of Ativan on 12/3/11. Per interview on 2/8/11 at 9:12 A.M. the facility's Assistant Administrator ADNS confirmed the Ativan PRN order was not discontinued and changed to every bedtime per the Physician's Order, and the medication was administered to Resident #32 on 12/3/11 as a PRN dose after the order to discontinue it.</p> <p>Also see F329.</p>	F 428			