

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 09/18/2024
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	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. 48017 Based on observations, interview, and record review, the facility failed to assess a resident for the ability to self-administer medications and initiate a care plan related to self-administration of medications for 2 of 8 sampled residents (Residents #82 and #92). Findings include: 1. Per interview on 9/16/24 at approximately 11:30 AM, Resident #92 was observed to have two medications in her/his room, the first called Mannitol Supplement (the label indicates it is a supplement that is useful to prevent urinary tract infections) and the second was an Albuterol Inhaler (used to treat difficulty breathing) on the windowsill. When s/he was asked what the medications were, s/he explained that family members bring in the Mannitol supplement as s/he has a history of urinary tract infections. S/he uses the Albuterol inhaler to prevent wheezing. S/he tells the nursing staff when s/he uses the inhaler and has not discussed the Mannitol so far. Resident #92 confirmed that s/he does not have a lock box to store his/her medications. Per interview on 9/18/2024 at approximately 8:06 AM with the ADON (Assistant Director of Nursing), s/he confirmed that Resident #92 uses an Albuterol inhaler independently but does not know of the Mannitol Supplement. S/he stated that residents who request to self-administer medications must be able to self-report the use of the medication, and they must have a medication self-administration assessment and a locked area to store the medication. S/he confirmed that Resident #92 did not have evidence of a self-administration assessment and that the self-administration of medications was not reflected on the Resident's care plan or in their medical record. Per interview on 9/17/2025 at approximately 2:20 PM, the Administrator confirmed that the facility does not have a policy for self-administration of medications. 40258 2. During an interview with Resident #82 on 9/16/24 at 12:06 PM there was one black pill in a medication cup on the over bed table. There were also two rust colored pills in a medication cup on the bedside table. When Resident #82 was asked what they were s/he pointed to the black pill and stated I was not taking my pills fast enough for the nurse this morning so s/he left this here for me to finish up. When asked what the two rust colored pills were s/he stated that they were Ibuprofen. The nurse leaves them here for me in case I need them. (continued on next page)		

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.

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

TITLE

(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per record review there was no documented evidence that Resident #82 had been assessed for the ability to self-administer medications. Review of Resident #82's care plan revealed no care plan for self-administration or medications left at bedside. There was also no physician order for self administration present in the record. Per interview with the Unit Manager on 9/16/2024 at approximately 3:30 PM, Resident #82 does not have a physicians order and has not been assessed or care planned for self-administration of medications. The Unit Manager confirmed that unless there is a self-administration assessment stating the Resident can self administer and medications can be left at bedside, the nurses should be staying with Resident #82 while s/he takes her/his medications and they should not be left at bedside.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 46135 Per interview and record review, the facility failed to provide activities of daily living care (ADL) based on resident preference for 1 of 32 sampled residents (Resident #11). Findings include: Per record review, Resident #11's care plan reads, [Resident #11] has an ADL self-care performance deficit [related to] Quadriplegia [paralysis of all four limbs], with the following interventions, DRESSING: [extensive] assistance by 1 staff to dress, revised on 8/21/22, and TRANSFER: Mechanical sist to stand Lift with extensive assist of 2 staff for transfers, revised on 5/26/24. On 7/16/24, Resident #11 was assessed to have a BIMS of 15 (brief interview for mental status; a cognitive assessment score indicating cognitive intactness). Per interview on 9/17/24 at 9:50 AM, Resident #11 stated that s/he prefers to get up by 8:00 AM or before breakfast. S/He explained that this preference is not always honored, as aides do not start his/her morning care until 9:00 AM about 1-3 times a week, and on a few occasions 10 AM or later. S/He revealed that s/he is frustrated because this has been happening for months and is upset that it is becoming the norm. On 9/18/24 at 10:47 AM, Resident #11 explained that this preference is an intervention in his/her care plan and has been for a while. S/He had also explained that s/he had sent an email to the social service department alerting them that his/her care plan preference is not always honored. Per record review of Resident #11's care plan, there are no interventions regarding his/her preference to get out of bed prior to 8 AM. A review of historical care plans reveals the following intervention was added on 4/9/21 resident request to be up by 8 am. This intervention was no longer in his/her care plan starting 11/6/23. Per review of a 2/19/24 email, Resident #11 emailed the social service department of his/her concern that s/he is not regularly getting out of bed before 8:00 AM. Per interview on 8/18/24 at 10:50 AM, the Unit Manager stated that s/he was aware that Resident #11 had a preference to get out of bed in the morning before 8:00 AM. S/He explained that Resident #11's preferences should be included in their care plan and Kardex (a quick reference of care plan interventions) and confirmed that it was not.		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29776 Based upon interview and record review, the facility failed to provide adequate supervision to prevent accidents resulting in harm to one resident [Res.#59] of 6 sampled residents. Findings include: Per review of Res.#59's medical record, the resident was admitted to the facility with diagnoses that included generalized muscle weakness, cerebral infarction [stroke], seizures, and dementia. Review of Res.#59's Care Plan reveals the resident was identified as at risk for falls related to a history of falls, dementia, hemiplegia [one-sided paralysis], anxiety, depression, and medications associated with increased fall risk. Regarding toilet use, the Care Plan records Res.#59 requires extensive assistance and sit to stand by 2 staff for toileting. An interview was conducted with the Director of Nursing [DON] on 9/18/24 at 10:02 AM. The DON stated that Licensed Nursing Assistants [LNAs] receive training during orientation regarding following a resident's Kardex. [the 'Kardex' is a documentation system that enables direct care staff to easily reference key patient information that shapes the resident's care plan.] Review of Res.# 59's Kardex for July and August 2024 reveals Res.#59 requires extensive assistance and sit to stand by 2 staff for toileting and regarding transfers, requires extensive assistance and sit to stand by 2 staff to move between surfaces. Per review of Progress Notes for Res.#59, dated 8/7/24, At approx. 6:15 AM this writer was called to [Res. #59's] room by LNA for reports of [Res.#59] falling in the bathroom .[Res.#59] was observed to be uncomfortable and expressing complaints of pain in right leg. Progress notes record at 10:23 AM Resident began to yell out in pain. Upon assessment, resident is touching [h/her] lower back as well as [h/her] right leg . Providers updated and ordered resident to be sent to [NAME] Regional Medical Center for evaluation. Per review of Emergency Department notes from [NAME] Regional Medical Center dated 8/7/24, Res. #59 was inappropriately moved by LNA- patient is a mechanical lift only. Right leg 'popped out' (rotated externally) as patient was pivoting while standing. Patient has dementia history, reports 'very bad' pain. Grimacing .Apparently patient usually utilizes a sit to stand and is unable to transfer on [h/her] own. This morning patient was being attended by a new medical staff who tried to get [h/her] to stand up and make a transfer on [h/her] own. Res.#59 underwent a series of x-rays on 8/7/24 which showed the resident suffered a Tibial plateau fracture (A tibial plateau fracture is an injury where you break your bone and damage the cartilage on top of your tibia (bottom part of your knee)). [https://Orthopaedic Trauma Association org/for-patients/find-info-body-part/3834#/+0/score, date_na_dt/desc]. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Per review of the facility's investigation of the incident on 8/7/24, it was determined that [LNA #1] did not understand that [Res.#59] required a sit to stand lift for transfers when assisting [him/her] in the restroom . LNA states [s/he] was aware resident was a 1 assist for care and 'assumed' [s/he] was a 1 assist for transfers. Per interview with the Director of Nursing [DON] on 9/18/24 at 10:02 AM, the DON stated LNA#1 was not familiar with Res.#59 and the resident's care requirements. The DON confirmed the facility's investigation demonstrated that Res.#59's Kardex contained the instructions of extensive assistance and sit to stand by 2 staff for toileting and transfers. The DON confirmed that on 8/7/24, contrary to training and specific instructions, LNA #1 attempted toileting and transfer of Res.#59 without a Sit to Stand device and without the assistance of another staff member. The attempted transfer without the proper device and additional staff resulted in harm to Res.#59 in the form of a fractured tibial plateau. The facility completed corrective actions after identifying this deficient practice, prior to the survey entrance; therefore, this deficiency is considered past noncompliance. Per the facility investigation, the facility educated the LNA involved, educated all nursing staff regarding the use of the Kardex and its purpose, and completed several weeks of audits regarding proper implementation of resident Kardex's, which were reviewed and verified.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46135 Based on interview and record review, the facility failed to provide pharmaceutical services to meet each resident's needs for 1 of 32 sampled residents (Resident #11). Findings include: Per record review, Resident #11 has diagnoses that include quadriplegia (paralysis of all four limbs) and muscle spasms. On 7/16/24, Resident #11 was assessed to have a BIMS of 15 (brief interview for mental status; a cognitive assessment score indicating cognitive intactness). On 9/18/24 at 10:47 AM, Resident #11 explained that for months, s/he misses 1-2 doses a month of his/her Finasteride and Dantrolene because the medications are not available from the pharmacy. S/He expressed that s/he is very frustrating because it has become a pattern, staff have not addressed the issue, and it continues to happen. Per record review, Resident #11 has a physician order for Dantrolene Sodium Oral Capsule 25 MG 1 capsule by mouth for muscle spasms, twice a day starting 11/30/23 and changing to three times a day starting on 8/22/24. Per review of Resident #11's Medication Administration Records (MAR) from 6/1/24 through 9/18/24, Resident #11 was not administered 7 prescribed doses of Dantrolene. One dose is left blank on the MAR for the following dates: 6/12/24, 8/8/24, 8/23/24, and 8/26/24. One does on 8/22/24 and two doses on 8/28/24 are marked 9 indicating a nursing note was written as to why it was not administered. Notes corresponding to these dates indicate that the Dantrolene medication was not available. Per record review, Resident #11 has a physician order for Finasteride Tablet 5 MG Give 0.5 tablet by mouth once a day for alopecia (hair loss) starting on 4/21/2018. Per review of Resident #11's MARs from 6/1/24 through 9/18/24, Resident #11 was not administered 6 prescribed doses of Finasteride. Doses on 6/12/24 and 8/7/24 are left blank on the MAR. Doses on 6/30/24, 7/1/24, 7/29/24, and 8/7/24 are marked as 9 and a dose on 9/17/24 is marked as 5, both indicating a nursing note was written as to why it was not administered. Notes corresponding to these dates indicate that the Finasteride medication was not available. Per interview on 8/18/24 at 1:46 PM, the Unit Manager explained that there have been issues with Resident #11 getting his/her Finasteride and Dantrolene regularly. S/He has contacted the pharmacy every month about this and it keeps happening. S/He explained that is happening with medications that are unable to be combined in a bubble pack and it is happening to other residents on the unit in addition to Resident #11. S/He explained that the leadership team is aware that there are issues with getting all resident medications from the pharmacy on time. Per interview on 8/18/24 at approximately 2:00 PM, the Administrator and Director of Nursing both confirmed that they were unaware that there have been issues with the pharmacy not delivering all ordered medications.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48017 Based on observation, interview, and record review, the facility failed to ensure medications were properly stored for 1 of 8 of the applicable sample (Resident # 92). Findings include: Per interview on 9/16/24 at approximately 11:30 AM, Resident #92 was observed to have two medications in her/his room, the first called Mannitol Supplement (the label indicates it is a supplement that is useful to prevent urinary tract infections) and the second was an Albuterol Inhaler (used to treat difficulty breathing) on the windowsill . When s/he was asked what the medications were, s/he explained that family members bring in the Mannitol supplement as s/he has a history of urinary tract infections. S/he uses Albuterol to prevent wheezing. S/he tells the nursing staff when s/he uses the inhaler and has not discussed the Mannitol so far. Resident #92 confirmed that s/he does not have a locked box to store their medications. S/he leaves them on the windowsill of his/her bedside table. Per interview with the Administrator on 9/17/2024 at approximately 10:05 AM, s/he confirmed that Resident #92 should have a lock box in their room to secure self-administered medications in. S/he also confirmed that the facility had no policy regarding securing self-administered medications.		

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F 0779 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep signed and dated reports of x-rays and other diagnostic services in the residents record. 46135 Per interview and record review, the facility failed to file in the resident's clinical record signed and dated x-ray reports for 1 of 32 residents (Resident #24). The failure to ensure radiology results were filed in the resident's clinical record placed him/her at risk for unmet care needs. Findings included: Record review reveals that Resident #24 had a physician order for a chest x-ray dated 8/29/24, and a left hand x-ray dated 6/25/24. A review of Resident #24's medical record does not include a signed and dated copy of the x-ray reports or results of either x-ray. The record does not include any physician or nursing documentation that the above x-ray reports were received and reviewed by the physician. Per interview on 9/18/24 at 12:17 PM, the Unit Manager (UM) explained that s/he is not aware of how x-ray reports are entered into a resident's record. S/He explained that the providers, who work for the community health center, not for the facility, do not utilize the facility's electronic health record system to document. The UM explained that the community health center providers have access to x-ray results through a portal that s/he does not have access to. The UM confirmed that the x-ray reports were not in Resident #24's facility medical record. Per interview on 9/18/24 at 12:54 PM, the Administrator and Director of Nursing explained that some facility staff do have access to the portal where x-ray results are kept but it is the provider's responsibility to upload the reports and their notes saying the reports were reviewed into the facility's medical record. Per interview on 9/18/24 at 3:53 PM, a community health center Advanced Practice Registered Nurse (APRN) explained that s/he receives most x-ray reports through a portal and will review them once they come in. S/He stated s/he is unsure how they get into the facility's medical record. If an x-ray result is faxed directly to the facility, s/he reviews them and then gives them back to the facility initialed and dated to indicate that they have been reviewed. The APRN is not sure what they do with the x-ray reports after that.		