

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

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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 07/08/2026
NAME OF PROVIDER OR SUPPLIER Rutland Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 46 Nichols 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interview and record review, the facility failed to ensure care plan interventions related to risk for skin breakdown were implemented for 1of 6 sampled residents (Resident #62). Findings include:Per review of Resident #62's record, diagnoses include chronic obstructive pulmonary disease, disorders of bone density and structure, spondylosis, need for assistance with personal care, dementia without behaviors, depression and anxiety. The resident was admitted to the facility on [DATE] for rehabilitation services following a hip fracture. The resident was then transferred to long term care services in the same facility on 4/12/2026.Per review of Resident 62's care plan a nursing diagnosis of at risk for skin breakdown is noted with an intervention of assist in turning and repositioning every 2-3hrs. to be initiated on 3/10/2026. Per review of Resident # 62's care plan a nursing diagnosis of [resident] requires assistance with ADL care. with an intervention added on 3/13/2026 of heel protector foot cushion w/anti-internal rotation adaption wedge.Per review of Resident #62's task/intervention record and progress notes there is no documentation of turning or repositioning every 2-3 hrs or the implementation of a heel protector foot cushion with anti-internal rotation adaption wedge.Per interview with 2 Licensed Nursing Assistants (LNA) on 7/8/2026 at 10:40 AM, they reported not having documentation of turning and repositioning Resident #62.Per interview with the 2 South Unit Manager (UM) on 7/8/2026 at 10:50 AM, she stated that turning/repositioning is only documented during the night shift.Per interview with the Director of Nursing (DON) on 7/8/2026 at 11:15 AM she states that the turning/repositioning intervention is assigned to all residents who are at risk for skin breakdown, but no documentation of the task is completed. When asked how she knows the task is being completed she said that when the resident is in bed they are turned and repositioned, but when they are in a wheelchair and do not want to be in the bed they are left alone stating we cannot make them move from one place to another. Copies of a facility generated Turning and Repositioning every 2 hours document was provided by the 3rd floor unit manager on 7/8/2026 at approximately 11:50 AM. She stated that the 2 hour time slots were initialed by nurses and not the LNAs. According to this documentation, Resident #62 was up in a wheelchair for 4-6 consecutive hours on the following dates in April: 13th, 14th, 15th, 16th, 17th, 18th, 19th, 20th, 21st, 22nd, 23rd, 25th, 27th, and 28th. No documentation of repositioning noted.The facility failed to provide sufficient documentation that care plan interventions of turning and repositioning of Resident #62 every 2-3 hrs. and the placement of a heel protector foot cushion w/anti-internal rotation adaption wedge were implemented.		

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care plan interventions related to prevention of pressure ulcers were implemented for 2 of 6 sampled residents (Residents #62 and #32). Findings include:1. Per review of Resident #62's record, s/he has a Brief Interview of Mental Status (BIMS) of 0 (severe cognitive impairment) and diagnoses include chronic obstructive pulmonary disease (COPD), disorders of bone density and structure, spondylosis (degenerative changes in the spine), need for assistance with personal care, dementia without behaviors, depression and anxiety. The resident was admitted to the facility on [DATE] for rehabilitation services following a hip fracture. Per review of Resident #62's progress notes dated 5/1/2026, a Licensed Nursing Assistant (LNA) reported pressure areas on both heels. A nursing assessment revealed bilateral pressure areas measuring 4cm (centimeters) by 4 cm on the right heel and 0.5 cm by 0.5 cm on the left heel. The progress note states, both heels have been skin prepped, floated on a pillow, and Mepilex dressing applied. Per review of the facility's Repositioning policy, dated 01/2026, Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation and providing pressure relief. Per review of Resident #62's Braden Scale (a tool used to assess a person's risk of developing pressure ulcers), s/he was categorized as moderate risk with a score of 13 on 3/10 and 3/31 and as high risk on 3/17 with a score of 11. According to the Braden Scale, a moderate to high-risk score indicates that a resident can occasionally make slight changes in body or extremity position but is unable to make frequent or significant changes independently and is dependent on staff for repositioning. Per interview with the Director of Nursing on 7/8/2026 at 11:15 AM, she confirmed that Resident #62 was identified as being at risk for pressure ulcer development due to clinical diagnoses and co-morbidities. Per review of Resident 62's care plan a nursing diagnosis of at risk for skin breakdown is noted with an intervention of assist in turning and repositioning every 2-3hrs (hours). to be initiated on 3/10/2026. Per review of Resident 62's care plan a nursing diagnosis of [resident] requires assistance with ADL care. with an intervention added on 3/13/2026 of heel protector foot cushion w/anti-internal rotation adaption wedge. Per review of Resident #62's task/intervention record and progress notes, there is no documentation of turning or repositioning ever 2-3 hrs. There is no documentation of staff placing a heel protector foot cushion w/anti-internal rotation adaption wedge. Per interview with an LNA on 7/8/2026 at 10:50 AM, he stated that they pretty much reposition residents who are in bed every 2-3 hrs. but do not document that they did it. When asked to see a task sheet with this intervention on it he stated he does not have anything like that. A second LNA stated (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that they have an intervention/task that they sign off on every shift (left to right rolling). Per review of the Documentation Survey Report, the resident is dependent on staff to complete left to right rolling. Documentation of staff performing this task was missing for the following shifts. 4/20/2026 evening shift 4/24/2026 evening shift 4/25/2026 evening shift 4/28/2026 day shift 4/30/2026 evening shift 4/30/2026 night shift Marked NA [not applicable] on 4/27/2026 and 4/30/2026 Per interview with the 2nd floor unit manager on 7/8/2026 at 10:50 AM, she stated that LNAs are supposed to be documenting every shift on the right to left rolling intervention record. She confirms that the above shifts are missing documentation and stated, they know they should be doing this. When asked about repositioning she stated that LNAs are supposed to be doing it every 2-3 hours on every shift, but that documentation is only completed on the night shift. She confirmed that not repositioning, along with other factors such as age and health status, could result in pressure injury. Per Interview with the DON on 7/8/2026 at 11:15 AM, she stated that the repositioning intervention is added to the care plan of all residents who are at risk for skin breakdown and they do not document the task. When asked about wheelchair repositioning, she stated that the facility cannot make the resident move from the wheelchair and that is their choice. Copies of a facility generated Turning and Repositioning document for April 12th through July 6th were provided by the 3rd floor unit manager on 7/8/2026 at approximately 11:50 AM. Each document covered 24 hrs. a day 7 days a week. According to this documentation, in the two weeks leading up to the discovery of pressure injuries on Resident #62's heels s/he was up in a wheelchair for 4-6 consecutive hours on the following dates in April: the 13th, 14th, 15th, 16th, 17th, 18th, 19th, 20th, 21st, 22nd, 23rd, 25th, 27th, and 28th with no documentation of offloading or repositioning noted. According to the National Pressure Injury Advisory Panel (NPIAP)(an organization which provides evidence-based guidelines in the prevention and treatment of pressure ulcers), common areas of pressure injury development when seated in a wheelchair are the: Occiput (back of the head) Scapula (shoulder blade) (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and to prevent skin breakdown, promote circulation and provide pressure relief for residents. General Guidelines Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. . Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. Upon entering Resident #32's room on 7/6/2026 at 12:35 PM there was a very strong, foul, fishy odor noted in the room. There was no evidence of any open food. Resident #32 was observed lying in bed with a blanket covering their legs. The bottom sheet, draw sheet (sheet used for moving a resident in bed), and positioning pillow under her/him were visibly soiled with what appeared to be wet with dark pinkish brown staining. Resident #32's spouse stated that Resident #32 chooses not to get out of bed and is dependent on staff for their care needs. At approximately 12:40 PM Licensed Nursing Assistant (LNA) #1 entered the room with a bag of supplies and stated that they were coming to get [Resident #32] cleaned up. The LNA left the bag on the chair and stated that they would be back. At 12:50 PM LNA #2 entered the room and set up Resident #32's lunch tray on their over bed table for her/him to eat their meal and left the room. Per interview on 7/6/2026 at 12:55 pm LNA #1 who was passing meal trays to other residents when asked when the last time Resident #32 was changed and repositioned, stated that she had not been able to get in to clean Resident #32 up for the day because the Resident had been busy and was talking with the surveyors when she came in to do so. The LNA confirmed that she had not assisted Resident #32 with care at all this day. Per phone interview on 7/7/2026 at 11:02 am LNA #3 who had been on duty on the night shift the morning of 7/6/2026 stated that she had checked on Resident #32 around 4:30- 5:00 AM, changed [her/him], and made [her/him] some tea. [Her/his] bottom has been a bit red here and there, and [s/he] had a bit of BM (bowel movement). [S/he] has moderate incontinence, and you check [her/him] every couple of hours and [s/he] is good. Per interview with LNA #2 on 7/7/2026 at 11:19 AM, Resident #32 does not get out of bed anymore. LNA #2 confirmed that Resident #32 had been incontinent in bed on 7/6/2026. She stated that she had not had a chance to get in to provide care because she had been the only LNA on the unit from 6:00 AM until 8:30 AM until LNA #1 came in. Per LNA #2, Resident #32's skin does have some soreness and staff reposition every two hours, reposition with pillows, and apply Z Guard (a zinc oxide barrier paste, used to treat or prevent moisture associated skin damage (MASD)). Per interview with LNA #2 on 7/7/2026 at approximately 1:45 PM, in the presence of the DON, Administrator, Assistant DON, and Registered Nurse, the LNA stated that she had misunderstood this surveyor on 7/7/2026 at 11:19 AM when asked when Resident #32 had last had care. She stated that she had actually checked and changed the Resident at 7:30 AM on 7/7/2026, and the Resident had not (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gone from 5:00 AM until 1:00 PM without care. However, the Resident had not been changed and repositioned from 7:30 AM - 1:00 PM, which is 5.5 hours. Per interview with LNA #4 on 7/8/2026 at 11:30 AM Residents who are care planned for turning and repositioning have a turning and repositioning form that LNAs fill out each shift. She produced a blank form, from a file and placed it on a clipboard to be completed. The LNA stated that the Unit Manager (UM) takes the forms once they have been completed. During an interview with the DON and UM on 7/8/2026 at approximately 11:40 PM, the Um stated that the LNAs do not document turning and repositioning residents every 2-3 hours, this is done in the record once per shift. Turning and repositioning forms are not part of the medical record, and they are just something she has implemented to keep the LNAs honest. The DON and UM confirmed that there is no documented evidence that Resident #32 has been turned and repositioned every 2-3 hours. Per interview with the Director of Nursing and the Administrator on 7/8/2026 at 1:05 PM the facility is currently reviewing pressure ulcer prevention in QAPI (quality assurance, performance improvement). They are making sure that staff are monitoring skin, doing weights, encouraging fluids, and reviewing whether they are seeing more MASD or pressure ulcers. Residents who are immobile and don't get out of bed are discussed in huddle and the care plan interventions are updated, weekly skin checks are implemented.		