STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475018	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Rutland Center for Nursing & Rehabili	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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review the facility failed to inform a resident representative in advance of the risks and benefits of the proposed care, the treatment alternatives, or other options for 1 of 5 sampled residents (Resident #86). Findings include:During an interview with the Resident's responsible party, on 9/30/202 at 9:24 AM, s/he said they had concerns with the number of falls that the Resident had been experiencing. S/he wonders what they are doing to prevent her/him from falling. S/he stated that s/he is concerned because they started her/him on a new medication to help her/him sleep at night. When asked what medication s/he was referring to s/he stated that s/he did not know but s/he worried that there was a reason for the falls that the Resident had been experiencing and the medicine would just make her/him sleep. Per record review a physician's order dated 8/28/2025 states Trazodone 25mg every 24 hours as needed for insomnia for 14 days at bedtime as needed for insomnia. Review of Resident #86's August and September Medication Administration Records (MARs) revealed that s/he received the Trazadone on 8/30, 8/31, 9/3, 9/5, 9/7, 9/9, and 9/11/25, seven times. There is no documented evidence that the Resident's record that facility obtained informed consent from Resident #86's responsible party for the as needed Trazadone. On 9/16/2025 a new physicians order for Trazadone one time daily was initiated. A progress note dated 9/17/2025, states that a message was left with the Resident's responsible party regarding starting new medication. A Psychoactive Medication Consent Form that was completed on 9/17/2025 states that verbal consent was received by the Resident's responsible party on 9/18/2025. This is 21 days after the initial as needed order was obtained.Per facility policy titled PRN [as needed] Psychotropic Medications Guidelines states, Obtain written consent for the administration of psychotropic medications in accordance with state and federal regulations. and The Healthcare Provider will document their discussion with the resident/responsible party regarding the risks and benefits of the use of the medication prescribed.Per facility policy titled Psychotropic Medications the policy statement states A consent from the resident and or responsible party will be obtained when the resident is started on a new psychoactive medication and as per state regulation. The resident and or representative will be notified when the dose of the psychoactive medication has been changed by the healthcare provider. Further review of Resident #86's record reveals a Physician's Note dated 9/16/2025 that states Patient is seen today at the request of her/his nurse for reports of insomnia. Patient had been on trazodone as needed at bedtime and this was quite helpful. Nursing asking if this can be scheduled .Patient appears stable. Nursing is requesting that patient has trazodone 25 mg scheduled for insomnia, this was on [her/his] medication administration record as needed and has follow-up. I have prescribed 25 mg trazadone nightly for insomnia. There was no documented evidence that the Physician discussed the risks, benefits, and treatment alternatives for the use of the trazodone. Per interview with the Unit Manager on 10/1/2025 at 11:00 AM she confirmed that there was no documentation regarding obtaining informed consent until 9/18/2025. Per interview with the facility Administrator, Director of Nursing, and Regional Quality Specialist on 10/1/2025 at 1:15 PM the Administrator confirmed that there was no evidence that the resident's representative had been provided informed consent prior to 9/18/2025.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview, and record review, the facility failed to notify a resident's representative of changes of condition for 1 of 28 residents in the sample (Resident #86). Findings include: Per observations made on 9/30/2025 at 12:50 PM, Resident #86 was seen self-propelling in their wheelchair attempting to leave the dining room. S/he was bare foot, and it was noted by the surveyors that s/he had a bruise on his/her right foot and toes. When asked what had happened to the Resident's foot, the Unit Manager (UM) stated that it happened when s/he was playing with her/his footboard and it fell off the bed and landed on her/his foot.During a phone interview with the Resident #86's Representative, on 9/30/25 at 9:24 AM, s/he said they had concerns with the number of falls that the Resident had been experiencing. S/he wondered what they are doing to prevent her/him from falling. S/he stated that s/he is concerned because they started her/him on a new medication to help her/him sleep at night. When asked what medication s/he was referring to s/he stated that s/he did not know but s/he worried that there was a reason for the falls that the Resident had been experiencing and the medicine would just make her/him sleep. The Resident's Representative stated that s/he had not known about the injury to the Resident's foot and toes prior to our call. Per interview with the UM on 10/1/2025 at 11:00 AM, the UM confirmed that the Resident's Representative had not been made aware of the injury to the Resident's right foot and toes. The UM stated that s/he had not realized that the Resident had a new injury to their right foot and was not sure of how long it had been there or how it happened.

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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 on interview and record review, the facility failed to create a comprehensive care plan related to incontinence care for 1 of 28 residents in a standard survey sample (Resident #64). Findings include:Per record review, Resident #64 was admitted with diagnoses that include paraplegia [paralysis of lower extremities], cognitive communication deficit, and anoxic brain injury, (a brain injury caused by a complete lack of oxygen to the brain). Resident has a BIMS score of 15 (Brief Interview for Mental Status, cognitive assessment indicating resident is cognitively intact). Per interview with Resident #64 on 9/30/2025 at 10:24 AM, s/he stated they are always incontinent of bowels and do not have sensation or knowledge of incontinence. The Resident stated they are not checked for incontinence after AM care, which occurs between 8:00 AM-10:00 AM, until 6:00 PM when they are assisted with PM care and helped back to bed. Per record review, Resident #64's Minimum Data Assessment (MDS) dated [DATE] indicates the resident is always incontinent of bowel function. Per a MDS assessment on 8/12/2024 indicates Resident #64 is always incontinent of bowels. Per record review, Resident #64's care plan initiated on 10/24/2024, they are not care planned for bowel incontinence. Per record review of bowel movement documentation from 9/1/2025-10/1/2025, all of Resident #64's bowel movements are documented as incontinent. Per interview with Unit Manager RN (Registered Nurse) on 10/1/2025 at 12:52 PM, they stated that the resident has a foley catheter and believes Resident #64 uses the bed pan for bowel movements.Per interview with Unit Manager RN, and Director of Nursing (DON) on 10/1/2025 at approximately 3:30 PM, the DON confirmed that a resident with chronic incontinence should be care planned for incontinence and confirmed that Resident #64 does not have a care plan for bowel incontinence.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observation, record review, and interview, the facility failed to ensure quality of care for 1 of 28 residents in a standard survey sample (Resident #15).Findings include:Per record review, Resident #15 has a medical diagnosis of type 1 diabetes mellitus with diabetic retinopathy [an eye disease that affects the retina and can lead to vision loss and blindness]. Resident #15's physician order for blood sugar monitoring reads: Nurse to check finger stick PRN [as needed], every 8 hours as needed for Prophylaxis, Finger sticks for Blood Sugar before meals and at bedtime for diabetic management.Per record review, Resident #15's care plan states, Resident has impaired visual function, has diagnosis of retinopathy. Has difficulty with large print but is able to do own blood sugar readings when placing monitor close to eyes, Nursing will read glucometer after resident checks their own blood glucose with an approved glucometer. Per record review of resident's face sheet, Special Instructions: meds WHOLE with THIN liquids; resident may NOT use their own glucometer; they can poke their own finger but must use our machine and allow us to see the number.Per observation during medication pass on 9/30/2025 at 8:47 AM, Licensed Practical Nurse #1 (LPN) stopped at Resident #15's room and asked, What was your sugar this morning? Resident #15 stated their sugar was 122. The nurse did not visualize the reading displayed on the glucometer, or the glucometer used to obtain the reading. Per interview on 10/1/2025 at 9:20 AM, the Medication Nurse Aide (MNA) stated staff assess Resident # 15's blood glucose by the resident's verbalization of the reading. The MNA stated that Resident #15 checks their blood glucose independently and records their readings on a personal log kept at their bedside.Per interview with LPN #1 on 10/1/2025 at 9:45 AM, they confirmed the resident doesn't use the facility provided glucometer but uses their personal glucometer that is the same as the facility uses. The nurse stated that staff are expected to observe Resident #15 prick their own finger, and independently collect the specimen and nursing verifies the reading by observing the result on the glucometer. LPN #1 confirmed that on 9/30/2025 they did not observe glucometer and assessed the residents blood glucose based on the resident's verbal report. LPN #1 confirmed Resident #15 has visual deficits.

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F 0689 Level of Harm - Minimal harm or potential for 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** Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent potential injury for 1 of 28 residents in the sample (Resident #86). Findings include: Review of Resident # 86's care plan revealed a care plan focus initiated on 5/1/2025 of risk for falls with and without injuries r/t, Parkinsons with dementia, Polyosteoarthritis, epilepsy, anemia and mild cognitive impairment, dependence on staff for ADL's [activities of daily living]. use of medications associated with increased risk for falls, impulsivity, and often sits on the floor and incontinence. An intervention initiated on 8/22/2025 states keep [Resident] out of other residents rooms.Per observation on 9/30/2025 at 12:50 PM, Resident #86 was seen self-propelling in their wheelchair attempting to leave the dining room. S/he was bare foot, and it was noted by the surveyors that s/he had a bruise on her right foot and toes.During a phone interview with the Resident #86's responsible party, on 9/30/202 at 9:24 AM, s/he said they had concerns with the number of falls that the Resident had been experiencing. S/he wondered what they are doing to prevent her/him from falling.An incident report dated 8/22/2025 reveals that at 1:00 PM Resident #86 was found in another resident's room and was sitting on the floor next to the bed. Further review of Resident #86's incident reports revealed that over the past 5 months, since 5/8/2025, the Resident has had 20 falls in their room and 19 of those falls were unwitnessed. The Resident had 4 falls in the dining room [ROOM NUMBER] of them were unwitnessed, and 2 unwitnessed falls in the hallway.Per review of Resident #86's care plan, there are no interventions in place that address that Resident #86 wanders throughout the unit and the need for increased supervision due to safety concerns related to wandering. Although there are multiple fall interventions in place, the facility has not identified the need for increased supervision of the Resident to prevent falls and other injuries. Per interview with the Unit Manager on 10/1/2025 at 11:00 AM, she confirmed that Resident #86 does wander throughout the unit and has had numerous unwitnessed falls.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, interview, and record review, the facility failed to conduct a trauma informed care assessment to establish possible triggers for re-traumatization for 1 of 2 residents in the sample (Resident #49). Findings include: During unit observations on 9/30/2025 at 10:02 AM Resident #49 was heard from the hall screaming and yelling out obscenities. S/He was found sitting in her/his wheelchair in her/his own bathroom alone. When asked if s/he was okay, s/he swore and said, no I am not ok. When asked if s/he needed help s/he said yes, now get the [expletive] out! The Resident continued screaming until a staff member was approached by a surveyor and was told that the Resident was alone in her/his bathroom screaming out. The staff member stated that this was not unusual behavior for the Resident. Per record review, Resident #49 has a diagnosis of post-traumatic stress disorder (PTSD). Review of the Resident's care plan revealed a care plan focus of mood problem r/t [related to] anxiety, PTSD, and [history] of passive [suicidal ideation] last revised on 7/18/2025. The care plan does not address possible triggers or any interventions to avoid or implement to manage anxiety, PTSD, or suicidal ideation. Upon further record review there was no documented evidence that the Resident was assessed for trauma or evaluated for possible triggers that may cause re-traumatization. Per interview on 10/1/2025 at 12:16 PM, the Social Worker said that the Resident had been living at the facility since 2019, before trauma became a focus. According to the Social worker they did not assess residents who were already in house at the time of the requirement to do so. The Social Worker confirmed that Resident #49 had not been assessed for trauma or triggers and that they did not know what sets her/him off. The Social Worker also confirmed that the care plan did not address the Resident's triggers.