VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

[phone] 802-241-0344
[fax] 802-241-0343

AGENCY OF HUMAN SERVICES

September 2, 2025

Ms. Lisa Blanchard, Administrator
Rutland Healthcare & Rehabilitation Center
46 Nichols Street
Rutland, VT 05701

Provider ID #: 475039

Dear Ms. Blanchard:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **August 5, 2025.** 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, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475039	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rutland Healthcare & Rehabilitation Center	**46 Nichols Street , Rutland, Vermont, 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
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of 1 complaint #2568573 on 8/5/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiency was Identified:	F0000	Rutland Center for Living and Rehabilitation provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law.	
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 3 residents sampled [Resident #1] was free from physical abuse by facility staff. A reasonable person has the expectation that they will be safe in their home and can trust and rely on staff to keep them safe. In this case, a reasonable person would suffer psychosocial harm of fear and or anxiety related to being abused by a staff member. Findings include: Per record review, Resident #1 was admitted to the facility with diagnoses that include dementia, major depressive disorder, anxiety, hallucinations, dissociate conversion disorder, and has a BIMS [brief	F0600	1. Residents residing in the facility have the potential to be affected by the alleged deficient practices. 2. Education provided to all staff on abuse policy and procedure 3. The facility reviewed and provided education on dementia training to include "if restive/combative with care, stop care and reproach at a later time. 4. The DNS or designee will do observational audits with staff during care of dementia resident to ensure proper approach is being followed for four (4) weeks, then monthly for two (2) months to monitor effectiveness of the plan. 5. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 6. Corrective action will be completed by August 29, 2025. **Tag F0600 POC accepted on 9/1/25 by T. Dougherty/S. Stem**	

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 reverse for further 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
	Administrator	8/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475039	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

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F0600 SS = G	Continued from page 1 interview for mental status] score of 7 indicating severe cognitive impairment. Review of the facility's "Abuse, Neglect, and Exploitation Prevention" policy [effective 3/23/2010] reveals "All residents of this facility have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect and misappropriation of property by facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members, legal guardians, friends or other individuals." Per review of the facility's investigation, on 7/20/25 Registered Nurse [RN] "reported that [s/he] and Licensed Nursing Assistant #1 [LNA #1] heard Resident #1 yelling. LNA #1 went to Resident #1's room to see what was going on… When LNA #1 came out, [s/he] reported that Resident #1's lip was bleeding. RN reports that [s/he] assessed Resident #1's lip and relayed to LNA #1 that [s/he] would start an incident report. LNA #2 [who was in the room when Resident #1 was heard yelling] and LNA #1 then went to provide care to another resident. After that care was completed, LNA #2 went to break, and LNA #1 reported to RN that LNA #2 admitted to [h/her] that [s/he] had hit Resident #1." Per the facility 5-day investigation summary, dated 7/23/25, LNA #2 reported to the Administrator that "[Resident #1] was combative during care. She reported that [Resident #1] hit her breast very hard and as a reaction, without thinking, she lashed out at [Resident #1] striking [him/her] in the face." The investigation states that the allegation that Resident #1 was physically abused by LNA #2 was verified. An interview was conducted with the facility's Administrator [ADM] on 8/5/25 at 11:30 AM. The ADM confirmed that the facility failed to ensure Resident #1 was free from abuse when LNA #2 struck the resident while providing care on 7/20/25.	F0600		