



Department of Disabilities, Aging and
Independent Living
Division of Licensing and Protection
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AGENCY OF *HUMAN SERVICES*

December 30, 2025

Ms. Melissa Haupt, Administrator
The Pines at Rutland Center for Nursing & Rehabilitation
99 Allen Street
Rutland, VT 05701

Provider ID #: 475018

Dear Ms. Haupt:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **December 17, 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,

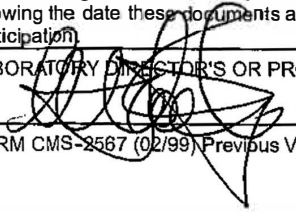
A handwritten signature in black ink that reads "Pamela M. Cota RN".

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: 475018		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/17/2025	
NAME OF PROVIDER OR SUPPLIER The Pines at Rutland Center for Nursing & Rehabilitation				STREET ADDRESS, CITY, STATE, ZIP CODE 99 Allen 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
E0000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review on 9/30/25 during the re-certification survey to determine compliance with 42 CFR Part 483.73 Emergency Preparedness requirements for Long Term Care Facilities. As a result of this review, the Facility was determined to be in substantial compliance with these requirements.			E0000	Please note the filing of the plan of Correction does not constitute admission to any of the alleged violations set forth in this statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all applicable laws and regulations.		
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey from 9/29/25 through 10/1/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:			F0000			
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by:			F0552			

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 Administrator	(X6) DATE 12/22/25
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

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F0552 SS = D	Continued from page 1 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			F0552	<u>F552</u> Resident #86 suffered no ill effects As A result of the alleged deficient practice. Consent for psychotropic medication Was Obtained on 9/18/2025 A facility-wide audit of residents with Psychotropic medications was Conducted to identify other Residents who have the potential to be impacted by the alleged Deficient practice. Nurses and providers have been educated on the policy For obtaining consent for Psychotropic Medications before administration Audits will occur weekly times 4, monthly Times 2 with results to QAPI. DNS or designee responsible Date of compliance: January 5, 2026		

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F0552 SS = D	Continued from page 2 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.			F0552	Tag F552 POC accepted on 12/30/25 by S. Davies/S. Stem		
F0580 SS = D	Notify of Changes (Injury/Degrade/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or			F0580			

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F0580 SS = D	Continued from page 3 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: 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.	F0580	<u>F580</u> Resident #86 suffered no ill effects As A result of the alleged deficient practice. Notification was completed on 10/1/25 A facility-wide audit of residents with A change in condition was Conducted to identify other Residents who have the potential to be impacted by the alleged Deficient practice. Nurses have been educated on the policy for change in condition notification Audits will occur weekly times 4, monthly Times 2 with results to QAPI. DNS or designee responsible Date of compliance: January 5, 2026 Tag F580 POC accepted on 12/30/25 by S. Davies/S. Stem				

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F0580 SS = D	Continued from page 4 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.			F0580			
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will			F0656			

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F0656 SS = D	Continued from page 5 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: 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 7/17/2025 indicates the resident is "always incontinent" of bowel function. Per a MDS	F0656	<u>F656</u> Resident #64 suffered no ill effects As A result of the alleged deficient practice. A care plan for bowel incontinence was Implemented on 10/15/2025 A facility-wide audit of residents with Bowel Incontinence was Conducted to identify other Residents who have the potential To be impacted by the alleged Deficient practice. Nurses have been educated on care planning For bowel incontinence Audits will occur weekly times 4, monthly Times 2 with results to QAPI. DNS or designee responsible Date of compliance: January 5, 2026 Tag F656 POC accepted on 12/30/25 by S. Davies/S. Stem	

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F0656 SS = D	Continued from page 6 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.		F0656	<u>F684</u> Resident #15 suffered no ill effects As A result of the alleged deficient practice. Resident no longer wishes to do her own Blood sugars A facility-wide audit of residents with Diabetes was Conducted to identify other Residents who have the potential to be impacted by the alleged Deficient practice. Nurses have been educated on the process For residents who perform their Own blood sugars. Audits will occur weekly times 4, monthly Times 2 with results to QAPI. DNS or designee responsible Date of compliance: January 5, 2026 Tag F684 POC accepted on 12/30/25 by S. Davies/S. Stem			
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: 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		F0684				

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F0684 SS = D	Continued from page 7 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.	F0684	<u>F689</u> Resident #86 suffered no ill effects As A result of the alleged deficient practice. Resident #86 care plan was updated On 10/9/2025 A facility-wide audit of residents who Wander was Conducted to identify other Residents who have the potential to be impacted by the alleged Deficient practice. Nurses and LNAs have been educated Regarding interventions for wandering Residents. Audits will occur weekly times 4, monthly Times 2 with results to QAPI. DNS or designee responsible Date of compliance: January 5, 2026 Tag F689 POC accepted on 12/30/25 by S. Davies/S. Stem				
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by:	F0689					

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F0689 SS = D	Continued from page 8 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 2 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.	F0689					
F0699	Trauma Informed Care	F0699					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475018		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/17/2025	
NAME OF PROVIDER OR SUPPLIER The Pines at Rutland Center for Nursing & Rehabilitation				STREET ADDRESS, CITY, STATE, ZIP CODE 99 Allen 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
F0699 SS = D	Continued from page 9 CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: 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.			F0699	<u>F699</u> Resident #49 suffered no ill effects As A result of the alleged deficient practice. Evaluation for PTSD was completed on 10/21/2025 A facility-wide audit of residents with PTSD was Conducted to identify other Residents who have the potential to be impacted by the alleged Deficient practice. Social services and admissions Have been educated on the policy for PTSD Audits will occur weekly times 4, monthly Times 2 with results to QAPI. Administrator or designee responsible Date of compliance: January 5, 2026 Tag F699 POC accepted on 12/30/25 by S. Davies/S. Stem		