

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury, VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

February 25, 2013

Ms. Wendy Beatty, Administrator  
Bennington Health & Rehab  
2 Blackberry Lane  
Bennington, VT 05201

Provider #: 475027

Dear Ms. Beatty:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **January 9, 2013**. 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  
Licensing Chief

PC:ne

Enclosure



FEB 21 2013

PRINTED: 02/01/2013  
FORM APPROVED  
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475027</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/09/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BENNINGTON HEALTH &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2 BLACKBERRY LANE BENNINGTON, VT 05201</b>
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(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
F 000	INITIAL COMMENTS	F 000	Preparation and/or execution of this plan of correction does not constitute the provider's admission of/or agreement with the alleged violations or conclusions set forth in this statement of deficiencies. This plan of correction is prepared and/or executed as required by state and federal laws.	
F 223 SS=E	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that 2 residents identified (Resident #1 and #2) were free from verbal, physical, and mental abuse. The findings include:</p> <p>1. Per review of the facility internal investigation on 12/27/12, Resident #1, had diagnoses that include Alzheimer's dementia with long and short term memory loss. Resident #1 is noted to be physically and verbally abusive with staff with hands on care. Per the internal investigation dated 10/19/12, Resident #1 was verbally abusive and combative during the overnight hours, yelling and screaming swear words at staff. Per documentation on the overnight of 10/19/12, a Licensed Nursing Assistant (LNA #1) told Resident #1 that the resident was "classless and unsophisticated" and if Resident #1 did not understand, LNA #1 would "dumb it down for</p>	F 223	<p>F223</p> <p>LNA # 1 and LNA #2 no longer are employed by the center.</p> <p>Resident #1 no longer resides at the center.</p> <p>Resident #2 is being provided with direct supervision while he or she is out of bed.</p> <p>Education will be provided to center staff on abuse and dealing with difficult behaviors; specifically aggressive behaviors.</p> <p>Nurse Managers will conduct;</p> <ul style="list-style-type: none"> <li>•direct observations of staff and resident interactions for compliance</li> <li>•direct observations of resident and resident interactions for potential resident to resident altercations</li> </ul> <p>Social Services will conduct random interviews of residents to monitor that they are not experiencing abuse from staff members.</p> <p>This will be done weekly x 4 and monthly x 4. Results will be reported through QAA.</p> <p>The date of compliance is February 26, 2013</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>WSB</i>	TITLE <i>EO</i>	(X6) DATE <i>2.13.13</i>
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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.

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F 223	<p>Continued From page 1</p> <p>[him/her]". Per documentation on the overnight of 10/19/12, LNA #2, who was trying to provide care to Resident #1, when Resident #1 called the LNA #2 a "bitch" among other names, LNA#2 called Resident #1 a "bitch" in return.</p> <p>Per review of the employee files of LNA #1, he/she received a counseling statement regarding approach and language with dementia residents dated 10/22/12 and then termination for unprofessional conduct on 10/24/12. Per review of the employee file of LNA #2, he/she was terminated from employment for inappropriate language with a resident with dementia.</p> <p>Per interview with the Director of Nursing on 1/9/13, he/she confirmed that LNA#1 and LNA#2 had been verbally abusive to Resident #1 and treated Resident #1 in an undignified manner.</p> <p>2. Per review of the nurses notes, Resident #1 was noted to be pulling residents out of their wheelchairs, pushing, tapping and touching other residents on the unit on 10/29/12. Per review of the nurses notes dated 10/31/12, Resident #1 was involved in a resident to resident altercation where Resident #1 was slapped by another resident. Per review of the nurses notes on 11/16/12, Resident #1 was involved in a resident to resident altercation with another female where Resident #1 was slapped by the female resident.</p> <p>Per review of the Social Service notes there's was no evidence that the SSD (Social Services Director) had assessed Resident #1 who was noted to be aggressive physically toward another resident on 10/29/12 by pulling the resident out of a wheelchair. Further review of the SS notes</p>	F 223	<p>Responsible: ADNS Nurse Mgr. &amp; SDC.</p> <p>F223 POC accepted 2/19/13 McWhan RN/PMC</p>	
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F 223	<p>Continued From page 2</p> <p>indicated there was no evidence that SS had assessed Resident #1 after Resident #1 had been aggressive toward other residents on 10/29/12 an 11/16/12.</p> <p>Per interview with the Social Service Director (SSD) on 1/9/12, he/she confirmed that he/she had not been informed of the aggressive actions of Resident #1 toward other residents on 10/29, or 11/16/12. The SSD confirmed that due to lack of communication regarding the incidents on 10/29, 10/31 and 11/16/12, the SSD did not assess the resident or review /revise the care plan to meet the specific needs and interventions that would help Resident #1 with his/her aggressive behaviors and potential needs of a victim of abuse.</p> <p>Per interview with the DNS and facility Administrator on 1/9/13, were unable to provide any investigations regarding the resident altercations that occurred on 10/29, 10/31, or 11/16/12. Per interview with the DNS on 1/9/13 and facility Administrator, the DNS confirmed he/she had not conducted complete and thorough investigations regarding the resident to resident altercations on 10/29, 10/31 and 11/16/12. Per interview on 1/9/13 with the DNS and facility Administrator they confirmed that the incidents of abuse on 10/29, 10/31 and 11/16/12 involving Resident #1 had not been called to the appropriate State agencies per regulatory requirements and facility policy.</p> <p>3. Per review of the medical record of Resident #2, he/she was admitted to the facility on 2/25/12 with diagnoses that included dementia with behavioral disturbances and senile psychotic</p>	F 223		
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F 223	<p>Continued From page 3</p> <p>conditions. Per the progress notes dated 9/22/12, Resident #2 was noted to have been in another residents room when Resident #2 was slapped in the chest by the resident occupying the room. Per review of the progress notes dated 10/29/12, Resident #2 was "yanked" out of his/her wheelchair by another resident.</p> <p>Per review of the progress notes dated 12/1/12, the notes indicate that Resident #2 was wandering in and out of residents rooms and he/she grabbed another resident by the forearm causing a skin tear. Per review of the progress notes Resident #2 was seen by staff on 12/9/12 in the hallway with red marks on his/her neck and scratches on his/her right cheek and chin area and three skin tears on his/her neck. Per the internal investigation provided by the Assistant Director of Nursing, Resident #2 was in another residents room when the resident that occupies the room got mad and admitted that he/she tried to physically remove Resident #2 from his/her room by grabbing him/her and Resident #2 sustained scratches and skin tears.</p> <p>Per review of the Social Service notes there was no evidence that the SSD had assessed Resident #2 who was noted in the progress notes to be aggressive physically toward another resident on 12/1/12. Further review of the SS notes indicated there was no evidence that SS had assessed Resident #2 after Resident #2 had been a victim of physical aggression by other residents on 9/22, 10/29, 12/1 and 12/9/12. Further review of the progress notes indicated that Resident #2 has a noted history of wandering in and out of other residents rooms and rummaging through their belongings. Per review of the SS notes there was</p>	F 223		
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F 223	<p>Continued From page 4</p> <p>no evidence Resident #2 was assessed for possible care needs after the 9/22, 10/29, 12/1 and 12/9/12 incidents where Resident #2 was the victim of abuse by another resident or physically aggressive towards other resident.</p> <p>Per review of the care plan titled "Behaviors/Mood, there is no evidence that the care plan was reviewed or revised to ensure that resident specific interventions and goals were created to ensure the safety of Resident #2 from abuse and management of Resident #2's aggressive behaviors towards other residents in the facility on 9/22, 10/29, 12/1 or 12/9/12.</p> <p>Per interview with the Social Service Director (SSD) on 1/9/12, he/she confirmed that he/she had not been informed that Resident #2 was the victim of physical aggression from other residents and Resident #2's physically aggressive actions toward other residents on 9/22, 10/29 or 12/9/12. The SSD confirmed that due to lack of communication regarding the incidents on 9/22, 10/29, 12/1/12 and 12/9/12 the SSD did not assess the resident or review /revise the care plan to meet the specific needs and interventions that would help Resident #2 with his/her aggressive behaviors and potential needs of a victim of physical aggression by other residents.</p> <p>Per interview with the DNS and facility Administrator on 1/9/13, they were unable to provide any investigations regarding the resident altercation that occurred on 9/22, 12/1, or 12/9/12. Per interview with the DNS on 1/9/13 and facility Administrator, the DNS confirmed he/she had not conducted complete and thorough investigations regarding the resident to resident altercations on</p>	F 223			

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F 223	Continued From page 5 9/22, 10/29, 12/1 or 12/9/12. Per interview on 1/9/13 with the DNS and facility Administrator they confirmed that the incidents of abuse on 9/22/12, and 12/1 or 12/9/12 involving Resident #2 had not been called to the appropriate State agencies per regulatory requirements and facility policy	F 223		
F 224 SS=E	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to implement written policies and procedures that prohibit mistreatment, neglect and abuse of 2 residents identified (Resident #1 and #2). The findings include:  1. Per review of the facility internal investigation on 12/27/12, Resident #1 had diagnoses that include Alzheimer's dementia with long and short term memory loss. Per review of the progress notes reviewed on 12/27 and 1/9/13, Resident #1 was noted to be pulling residents out of their wheelchairs, pushing, tapping and touching other residents on the unit on 10/29/12. Per review of the nurses notes dated 10/31/12, Resident #1 was involved in a resident to resident altercation	F 224	F224  Resident #1 no longer resides at the center  Resident #2 is being provided with direct supervision while he or she is out of bed.  Education on abuse policies and procedures will be provided to center staff.  Random audits will be conducted to monitor that the center's abuse policies and procedures are being followed. This will be done weekly x 4 and monthly x 4. Results will be reported through QAA.  The date of compliance is February 26, 2013  <i>Responsible: ADNS Nurse Mgr ? SOC.</i>  <i>F224 POC accepted 2/19/13 McLuhan RN / PMC</i>	

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F 224	<p>Continued From page 6</p> <p>where Resident #1 was slapped by another resident. Per the nurses notes on 11/16/12, Resident #1 was involved in a resident to resident altercation with another female where Resident #1 was slapped by the female resident.</p> <p>Per review of the facility policy titled "Elder Justice Act" regarding "Abuse Reporting" dated 12/8/2010, the policy indicates that reporting of abuse is to be completed within 24 hours if there is a suspicion of abuse, neglect or mistreatment.</p> <p>Per interview with the DNS and facility Administrator on 1/9/13, they were unable to provide any investigations regarding the resident altercations that occurred on 10/29, 10/31, or 11/16/12. Per interview on 1/9/13 with the DNS and facility Administrator they confirmed that the incidents of abuse on 10/29, 10/31 and 11/16/12 involving Resident #1 had not been called to the appropriate State agencies per regulatory requirements and facility policy</p> <p>2. Per review of the medical record of Resident #2, he/she was admitted to the facility on 2/25/12 with diagnosis that included dementia with behavioral disturbances and senile psychotic conditions. Per the progress notes dated 9/22/12, Resident #2 was noted to have been in another residents room when Resident #2 was slapped in the chest by the resident occupying the room. Per review of the progress notes dated 10/29/12, Resident #2 was "yanked" out of his/her wheelchair by another resident.</p> <p>Per review of the progress notes dated 12/1/12, the notes indicate that Resident #2 was wandering in and out of residents rooms and</p>	F 224			

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F 224	<p>Continued From page 7</p> <p>he/she grabbed another resident by the forearm causing a skin tear. Per review of the progress notes Resident #2 was seen by staff on 12/9/12 in the hallway with red marks on his /her neck and scratches on his/her right cheek and chin area and three skin tears on his/her neck.. Per the internal investigation provided by the Assistant Director of Nursing, Resident #2 was in another residents room when the resident that occupies the room got mad and admitted that he/she tried to physically remove Resident #2 from his/her room by grabbing him/her and Resident #2 sustained scratches and skin tears.</p> <p>Per review of the facility policy titled "Elder Justice Act" regarding "Abuse Reporting" dated 12/8/2010, the policy indicates that reporting of abuse is to be completed within 24 hours if there is a suspicion of abuse, neglect or mistreatment</p> <p>Per interview with the DNS on 1/9/13 and facility Administrator, the DNS confirmed he/she had not conducted complete and thorough investigations regarding the resident to resident altercations on 9/22, 10/29, 12/1 or 12/9/12. Per interview on 1/9/13 with the DNS and facility Administrator they confirmed that the incidents of abuse on 9/22/12, 12/1 or 12/9/12 involving Resident #2 had not been called to the appropriate State agencies per regulatory requirements and facility policy</p>	F 224		
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have</p>	F 225		

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F 225	<p>Continued From page 8</p> <p>had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that all alleged violations are thoroughly investigated, and must prevent</p>	F 225	<p>F225</p> <p>Resident #1 no longer resides at the center.</p> <p>Resident #2 is being provided with direct supervision while he or she is out of bed.</p> <p>Incidences of allegations of abuse are being reported as required to the appropriate state agency and investigated thoroughly.</p> <p>Residents who reside at the center have the potential to be affected.</p> <p>Education has been provided to the Center Leadership on elder abuse act regarding abuse reporting, resident to resident altercation reporting requirements, completing thorough investigations, and review of the results for corrective action.</p> <p>Center licensed nursing staff will be provided with education of steps to take to prevent further potential abuse while the investigation is in progress.</p> <p>Audits will be conducted of incidences of resident to resident altercations to monitor that such incidences are reported as required, investigated thoroughly, and the results of such investigations are reviewed by the Administrator. Results will be reported through QAA.</p> <p>Date of compliance is February 26, 2013 <i>F225 POC accepted 2/19/13 McLuhhan RW / Pmc</i></p>		

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(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	
F 225	<p>Continued From page 9</p> <p>further potential abuse while the investigation is in progress for 2 residents identified (Resident #1 and #2). The findings include.</p> <p>1. Per review of the nurses notes on 12/27/12 and 1/9/13, Resident #1 was noted to be pulling residents out of their wheelchairs, pushing, tapping and touching other residents on the unit on 10/29/12. Per review of the nurses notes dated 10/31/12, Resident #1 was involved in a resident to resident altercation where Resident #1 was slapped by another resident. Per the nurses notes on 11/16/12, Resident #1 was involved in a resident to resident altercation with another female where Resident #1 was slapped by the female resident.</p> <p>Per review of the facility policy titled "Abuse Reporting" dated 12/8/2010, the policy indicates that reporting of abuse is to be completed within 24 hours if there is a suspicion of abuse, neglect or mistreatment</p> <p>Per interview with the DNS and facility Administrator on 1/9/13, they were unable to provide any investigations regarding the resident altercations that occurred on 10/29, 10/31, or 11/16/12. Per interview with the DNS on 1/9/13 and facility Administrator, the DNS confirmed he/she had not conducted complete and thorough investigations regarding the following resident to resident altercations on 10/29, 10/31 and 11/16/12. Per interview on 1/9/13 with the DNS and facility Administrator they confirmed that the incidents of abuse on 10/29, 10/31 and 11/16/12 involving Resident #1 had not been reported to the appropriate State agencies per regulatory requirements.</p>	F 225			

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F 225	Continued From page 10  2. Per review of the medical record of Resident #2, he/she was admitted to the facility on 2/25/12 with diagnoses that included dementia with behavioral disturbances and senile psychotic conditions. Per the progress notes dated 9/22/12, Resident #2 was noted to have been in another residents room when Resident #2 was slapped in the chest by the resident occupying the room. Per review of the progress notes dated 10/29/12, Resident #2 was "yanked" out of his/her wheelchair by another resident.  Per review of the progress notes dated 12/1/12, the notes indicate that Resident #2 was wandering in and out of residents rooms and he/she grabbed another resident by the forearm causing a skin tear. Per review of the progress notes Resident #2 was seen by staff on 12/9/12 in the hallway with red marks on his /her neck and scratches on his/her right cheek and chin area and three skin tears on his/her neck.. Per the internal investigation provided by the Assistant Director of Nursing, Resident #2 was in another residents room when the resident that occupies the room got mad and admitted that he/she tried to physically remove Resident #2 from his/her room by grabbing him/her and Resident #2 sustained scratches and skin tears.  Per review of the facility policy titled "Elder Justice Act" regarding "Abuse Reporting" dated 12/8/2010, the policy indicates that reporting of abuse is to be completed within 24 hours if there is a suspicion of abuse, neglect or mistreatment  Per interview with the DNS on 1/9/13 and facility Administrator, the DNS confirmed he/she had not	F 225			

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F 225	Continued From page 11 conducted complete and thorough investigations regarding the resident to resident altercations on 9/22, 10/29, 12/1 or 12/9/12. Per interview on 1/9/13 with the DNS and facility Administrator they confirmed that the incidents of abuse on 9/22/12, and 10/29 involving Resident #2 had not been called to the appropriate State agencies per regulatory requirements and facility policy.	F 225	F250  Resident #1 no longer resides at the center.  Resident #2 has been assessed by Social Services and his or her care plan updated to meet the specific needs and interventions that will help Resident #2 with his or her aggressive behaviors and potential needs of a victim of physical aggression by other residents.		
F 250 SS=E	<b>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</b>  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of 2 residents identified (Resident #1 and #2). The findings include:  1. Per of the facility internal investigation on 12/27/12, Resident #1, has diagnoses that include Alzheimer's dementia with long and short term memory loss. Resident #1 is noted to be physically and verbally abusive with staff with hands on care. Per the internal investigation dated 10/19/12, Resident #1 was verbally abusive and combative during the overnight hours, yelling and screaming swear words at staff. Per documentation on the overnight of 10/19/12, a Licensed Nursing Assistant (LNA #1)	F 250	Residents who have aggressive behaviors and/or are the victim of physical aggression by other residents are identified as having the potential to be affected.  Education has been provided to social services staff on updating care plans for residents who have aggressive behaviors and/or are involved in resident to resident physically aggressive altercations.  Audit of social service interventions will be audited by the administrator weekly x 4 and monthly x 4. Results will be reported through QAA  Date of compliance is February 26, 2013  <i>Responsible: ADNS Nurse Mgr E SOC</i>  <i>F250 POC accepted 2/19/13 mcuihan RN/PMC</i>		

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F 250	<p>Continued From page 12</p> <p>told Resident #1 that the resident was "classless and unsophisticated" and if Resident #1 did not understand, LNA#1 would "dumb it down for [him/her]". Per documentation on the overnight of 10/19/12, LNA #2, who was trying to provide care to Resident #1, when Resident #1 called LNA #2 a "bitch" among other names, LNA #2 called Resident #1 a "bitch" in return.</p> <p>Per review of the Social Service notes there was no evidence that the Social Service Director (SSD) assessed Resident #1 who was a victim of verbal abuse by two LNA's on 10/19/12.</p> <p>Per interview with the Social Service Director on 1/9/13, he/she indicated that no one had informed him/her that Resident #1 had been the victim of abuse by two LNA's on 10/19/12, and had not met with and assessed the potential needs of Resident #1 as a victim of abuse.</p> <p>2. Per review of the nurses notes Resident #1 was noted to be pulling residents out of their wheelchairs, pushing, tapping and touching other residents on the unit on 10/29/12. Per review of the nurses notes dated 10/31/12, Resident #1 was involved in a resident to resident altercation where Resident #1 was slapped by another resident. Per the nurses notes on 11/16/12, Resident #1 was involved in a resident to resident altercation with another female where Resident #1 was slapped by the female resident.</p> <p>Per review of the Social Service notes there's was no evidence that the SSD had assessed Resident #1 who was noted to be aggressive physically toward another resident on 10/29/12 by pulling the resident out of a wheelchair. Further</p>	F 250		
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F 250	<p>Continued From page 13</p> <p>review of the SS notes there was no evidence that SS had assessed Resident #1 after Resident #1 had been aggressive toward other residents on 11/16/12. The was no evidence in the SS notes that Resident #1 was assessed for possible needs after the 10/31/12 incident where Resident #1 was the victim of abuse by another resident who hit Resident #1.</p> <p>Per interview with the Social Service Director (SSD) on 1/9/12, he/she confirmed that he/she had not been informed of the aggressive actions of Resident #1 toward other residents on 10/29, or 11/16/12. The SSD confirmed that due to lack of communication regarding the incidents on 10/29, 10/31 and 11/16/12, the SSD did not assess the resident for specific needs and interventions that would help Resident #1 with his/her aggressive behaviors and potential needs of a victim of abuse</p> <p>3. Per review of the medical record of Resident #2, he/she was admitted to the facility on 2/25/12 with diagnosis that included dementia with behavioral disturbances and senile psychotic conditions. Per the progress notes dated 9/22/12, Resident #2 was noted to have been in another residents room when Resident #2 was slapped in the chest by the resident occupying the room. Per review of the progress notes dated 10/29/12, Resident #2 was "yanked"out of his/her wheelchair by another resident.</p> <p>Per review of the progress notes dated 12/1/12, the notes indicate that Resident #2 was wandering in and out of residents rooms and he/she grabbed another resident by the forearm causing a skin tear. Per review of the progress</p>	F 250			

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F 250	<p>Continued From page 14</p> <p>notes Resident #2 was seen by staff on 12/9/12 in the hallway with red marks on his /her neck and scratches on his/her right cheek and chin area and three skin tears on his/her neck.. Per the internal investigation provided by the Assistant Director of Nursing, Resident #2 was in another residents room when the resident that occupies the room got mad and admitted that he/she tried to physically remove Resident #2 from his/her room by grabbing him/her and Resident #2 sustained scratches and skin tears.</p> <p>Per review of the Social Service notes there's was no evidence that the SSD had assessed Resident #2 who was noted in the progress notes to be aggressive physically toward another resident on 12/1/12 : Further review of the SS notes indicated there was no evidence that SS had assessed Resident #2 after Resident #2 had been a victim of physical aggression by other residents on 9/22, 10/29, 12/1 and 12/9/12. Further review of the progress notes indicated that Resident #2 has a noted history of wandering in and out of other residents rooms and rummaging through their belongings. Per review of the SS notes there was no evidence Resident #2 was assessed for possible care needs after the 9/22, 10/29, 12/1 and 12/9/12 incidents where Resident #2 was the victim of abuse by another resident or physically aggressive towards other resident.</p> <p>Per review of the care plan titled "Behaviors/Mood, there is no evidence that the care plan was reviewed or revised to ensure that resident specific interventions and goals were created to ensure the safety of Resident #2 from abuse and management of Resident #2's</p>	F 250			

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F 250	Continued From page 15 aggressive behaviors towards other residents in the facility on 9/22, 10/29, 12/1 or 12/9/12.  Per interview with the Social Service Director (SSD) on 1/9/12, he/she confirmed that he/she had not been informed that Resident #2 was the victim of physical aggression from other residents and Resident #2's physically aggressive actions toward other residents on 9/22, 10/29 or 12/9/12. The SSD confirmed that due to lack of communication regarding the incidents on 9/22, 10/29, 12/1 and 12/9/12 the SSD did not assess the resident or review /revise the care plan to meet the specific needs and interventions that would help Resident #2 with his/her aggressive behaviors and potential needs of a victim of physical aggression by other residents.	F 250		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280  Resident #1 no longer resides at this center.  The care plan for Resident #2 is reflective of his or her individual needs related to behaviors, potential for being a victim of abuse, and being the aggressor of abuse.  Residents who reside at the center are identified as having the potential to be affected.  Education will be provided for center staff on reviewing and revising resident care plans; specifically for behavior management interventions and resident to resident altercations.  Care plan audits will take place weekly x 4 and then monthly x 4 with results reported through the QAA process.  Date of correction for F280 is February 26, 2013.  <i>Responsible: AONS Nurse Mgr &amp; SDC.</i>	

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*F280 POC accepted 2/14/13  
McWhan RN / PMC*

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F 280	Continued From page 16  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to review and revise the care plan of 2 residents identified (Resident #1 and #2) to ensure that there were resident specific interventions that met the residents needs. The findings include:  1. Per review of the facility internal investigation on 12/27/12, Resident #1 has diagnoses that include Alzheimer's dementia with long and short term memory loss. Resident #1 is noted to be physically and verbally abusive with staff with hands on care. Per the internal investigation dated 10/19/12, Resident #1 was verbally abusive and combative during the overnight hours, yelling and screaming swear words at staff. Per documentation on the overnight of 10/19/12, a Licensed Nursing Assistant (LNA #1) told Resident #1 that the resident was "classless and unsophisticated" and if Resident #1 did not understand, LNA #1 would "dumb it down for [him/her]". Per documentation on the overnight of 10/19/12, LNA #2, who was trying to provide care to Resident #1, when Resident #1 called the LNA #2 a "bitch" among other names, LNA #2 called Resident #1 a "bitch" in return.  Per review of the comprehensive care plan Resident #1 there was no evidence that the care plan had been reviewed and revised to meet the specific needs of Resident #1 as an actual victim of abuse and what interventions would be utilized	F 280			

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F 280	<p>Continued From page 17 to prevent reoccurrence.</p> <p>Per interview with the Social Service Director on 1/9/13, he/she confirmed that the care plan for Resident #1 had not been reviewed and revised to ensure that the plan of care met the specific needs of Resident #1 being the actual victim of abuse and interventions to prevent reoccurrence.</p> <p>2. Per review of the nurses notes on 12/27/12, the notes dated 11/16/12 indicated that Resident #1 was involved in a resident to resident altercation with another female where Resident #1 was slapped by the female resident. Per review of the comprehensive care plan of Resident #1, there was no evidence that the care plan had been reviewed and revised to meet the specific needs of Resident #1 as an actual victim of abuse and what interventions would be utilized to prevent reoccurrence.</p> <p>Per interview with the Social Service Director on 1/9/13, he/she confirmed that the care plan for Resident #1 had not been reviewed and revised to ensure that the plan of care met the specific needs of Resident #1 being the actual victim of abuse and interventions to prevent reoccurrence.</p> <p>3. Per review of the medical record of Resident #2, he/she was admitted to the facility on 2/25/12 with diagnoses that included dementia with behavioral disturbances and senile psychotic conditions. Per the progress notes dated 9/22/12, Resident #2 was noted to have been in another residents room when Resident #2 was slapped in the chest by the resident occupying the room. Per review of the progress notes dated 10/29/12, Resident #2 was "yanked" out of his/her</p>	F 280			

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F 280	<p>Continued From page 18 wheelchair by another resident.</p> <p>Per review of the progress notes Resident #2 was seen by staff on 12/9/12 in the hallway with red marks on his /her neck and scratches on his/her right cheek and chin area and three skin tears on his/her neck. Per the internal investigation provided by the Assistant Director of Nursing, Resident #2 was in another resident's room when the resident that occupies the room got mad and admitted that he/she tried to physically remove Resident #2 from his/her room by grabbing him/her and Resident #2 sustained scratches and skin tears.</p> <p>Per review of the progress notes dated 12/1/12, the notes indicate that Resident #2 was wandering in and out of residents rooms and he/she grabbed another resident by the forearm causing a skin tear.</p> <p>Per review of the care plan titled "Behaviors/Mood, there is no evidence that the care plan was reviewed or revised to ensure that resident specific interventions and goals were created to ensure the safety of Resident #2 from abuse, and management of Resident #2's aggressive behaviors towards other residents in the facility on 9/22, 10/29, 12/1 or 12/9/12.</p> <p>Per interview with the Social Service Director (SSD) on 1/9/12, he/she confirmed that he/she had not been informed that Resident #2 was the victim of physical aggression from other residents and Resident #2's physically aggressive actions toward other residents on 9/22, 10/29, 12/1 or 12/9/12. The SSD confirmed that due to lack of communication regarding the incidents on</p>	F 280		
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(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
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F 280	Continued From page 19 9/22, 10/29, 12/1 and 12/9/12 the SSD did not assess the resident or review /revise the care plan to meet the specific needs and interventions that would help Resident #2 with his/her aggressive behaviors and potential needs of a victim of physical aggression by other residents.	F 280		
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*WJB*  
*2-13-13*