

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

March 8, 2013

Ms. Melissa Craig, Administrator
Rowan Court Health & Rehab
378 Prospect Street
Barre, VT 05641-5421

Provider #: 475037

Dear Ms. Craig:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **January 30, 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

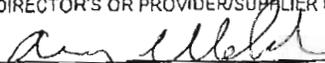


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/30/2013
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NAME OF PROVIDER OR SUPPLIER DOWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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4: 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 An unannounced on-site complaint investigation was initiated by the Division of Licensing and Protection on 1/23/2013 and concluded on 1/30/13. As a result of the investigation, Immediate Jeopardy was identified which also resulted in a determination of Substandard Quality of Care. An extended survey was completed on 1/30/13. The following are the regulatory findings from the investigation and extended survey.	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 law.	
F 202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that there was specific documentation within the medical record for 1 of 10 residents identified (Resident #1) by the residents physician of the necessity for the discharge, what was tried prior to the discharge to prevent the need for discharge and why the facility can no longer meet the specific needs of the resident being transferred. The findings include:	F 202	<u>F202 483.12(a)(3)</u> <u>DOCUMENTATION FOR</u> <u>TRANSFER/DISCHARGE</u> Corrective action accomplished for those residents found to have been affected; Resident #1 no longer resides at the facility. How the facility will identify other residents having the potential to be affected and what corrective action has been taken; IDT will identify each resident who has behaviors through walking rounds.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 2/25/13
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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.

PMC

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OMB NO. 0938-0391

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F 202	<p>Continued From page 1</p> <p>1. Per review of the medical record on 1/23/13, Resident # 1 was admitted to the facility on 7/5/11 with diagnoses that include; early onset Alzheimer's, memory loss, and depressive disorder. Per review of the progress notes by the Unit Manager, he/she indicated that Resident # 1 was discharged from the facility on 8/5/12 related to Resident #1 "frightening staff and residents". Per documentation in the medical record on 8/5/12 at 2:56 PM, the Registered nurse indicated that Resident #1 was "transferred to ER for severe agitation, combativeness, disrobing and refusal to be controlled". Per review of the physician's orders, a verbal order was obtained from a physician at 6:00 PM to "transport to CVMC ER".</p> <p>Per review of the clinical record, there was no evidence in the physicians progress notes indicating the specific need for Resident #1 to be discharged to the emergency room, there was no evidence in the clinical record by the physician of what interventions were utilized to assist Resident #1 with his/her behaviors and how and why interventions were not successful and how the facility was unable to meel the needs of Resident #1 at the facility.</p> <p>Per review of the facility policy titled "Physician Services", the policy indicates that "Physicians orders and progress notes shall be maintained in accordance with current OMBRA regulations and facility policy."</p> <p>Per review of the clinical record by the Interim Director of Nursing (IDNS) on 1/30/13, he/she confirmed that there was no documentation by the facility physician in the clinical record of</p>	F 202	<p>Residents identified as having behaviors will be reviewed by the IDT, plan of care reviewed, physician and psychologist consulted, and a behavior management plan developed.</p> <p>Measures or systemic changes put into place to ensure that the deficient practice will not recur;</p> <p>A Behavior Management Team will be established, including membership minimally by nursing, social service, activities, rehabilitation, and psychologist. This team will meet weekly and conduct behavior management rounds. The resident's attending physician will be notified of behavior round team assessments.</p> <p>Physician and physician extender staff will be provided with education on documentation required when a resident is transferred or discharged due to the following circumstances;</p>	

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F 202	<p>Continued From page 2</p> <p>Resident #1 regarding the specific need for Resident #1 to be discharged to the emergency room. The IDNS confirmed the documentation he/she reviewed some was illegible and the rest of the review of the progress notes written by the physician that there was no evidence in the clinical record by the physician of what interventions were utilized to assist Resident #1 with his/her behaviors and how and why interventions were not successful and how the facility was unable to meet the needs of Resident #1 at the facility. Per interview with the IDNS and the Interim Administrator, on 1/30/13, they confirmed that the expectation is that the resident physician document in the medical record according to the regulatory requirements.</p> <p>2. Per review of the medical record on 1/23/13, it was documented by the Licensed Practical Nurse (LPN) Resident #1 on 9/27/12 at 3:56 AM was "in the main dining room and struck another resident forcefully in the ear with a spoon" and "Resident #1 was throwing silverware through the dining room... As resident passed near this writer, [he/she] continuously struck/attempted to strike me....[The IDNS] was consulted and instructed writer to contact resident's doctor to transport to CVH ED [Central Vermont Hospital Emergency Department]. Order was received and resident transported to CVH ED."</p> <p>Per review of the clinical record indicated that there was no evidence in the physicians progress notes indicating the specific need for Resident #1 to be discharged to the emergency room, there was no evidence in the clinical record by the physician of what interventions were utilized to</p>	F 202	<ul style="list-style-type: none"> • Transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility • Transfer or discharge is appropriate because the residents' health has improved sufficiently and the resident no longer needs the services required by the facility • The health of the individuals in the facility would otherwise be endangered. <p>How the corrective actions will be monitored to ensure that the deficient practice does not recur/quality assurance program;</p> <p>Residents who are displaying exacerbated behaviors will be identified during Concurrent Review. The residents will be reviewed by the Behavior Management team, a medical</p>

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F 202	Continued From page 3 assist Resident #1 with his/her behaviors and how and why interventions were not successful and how the facility was unable to meet the needs of Resident #1 at the facility. Per review of the facility policy titled "Physician Services", the policy indicates that "Physicians orders and progress notes shall be maintained in accordance with current OMBRA regulations and facility policy." Per review of the clinical record by the Interim Director of Nursing (IDNS) on 1/30/13, he/she confirmed that there was no documentation by the facility physician in the clinical record of Resident #1 regarding the specific need for Resident #1 to be discharged to the emergency room. The IDNS confirmed the documentation he/she reviewed some was illegible and the rest of the review of the progress notes written by the physician that there was no evidence in the clinical record by the physician of what interventions were utilized to assist Resident #1 with his/her behaviors and how and why interventions were not successful and how the facility was unable to meet the needs of Resident #1 at the facility. Per interview with the IDNS and the Interim Administrator, on 1/30/13, they confirmed that the expectation is that the resident physician document in the medical record according to the regulatory requirements. 3. Per review of the medical record on 1/23/13, it was documented by an LPN on 10/11/12 at 1:19 AM, Resident #1 slapped/pushed another resident to the floor causing injury. "[The ADNS/DNS] telephoned/made aware of this	F 202	record review conducted, plan of care revised as warranted, and interventions implemented. The Director of Nursing or Regional Director/Quality Improvement Nurse will audit medical records for residents transferred/discharged to ensure that documentation of medical management and reason for transfer is addressed. Results of the audits will be reviewed and submitted to the facilities QAPI meeting for trending and tracking with remedial measures initiated as identified. Person Responsible; The Director of Nursing Date of Correction; March 1, 2013. <i>F202 POC accepted 2/26/13 Mullinon RNP/PMC</i>		

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F 202	Continued From page 4 incident. Instructed by DNS, to telephone MD, get an order to transport to CVH for evaluation." Per review of the clinical record indicated that there was no evidence in the physicians progress notes indicating the specific need for Resident #1 to be discharged to the emergency room, there was no evidence in the clinical record by the physician of what interventions were utilized to assist Resident #1 with his/her behaviors and how and why interventions were not successful and how the facility was unable to meet the needs of Resident #1 at the facility, and sent to the emergency room on 10/11/12. Per review of the clinical record by the Interim Director of Nursing (IDNS) on 1/30/13, he/she confirmed that there was no documentation by the facility physician in the clinical record of Resident #1 regarding the specific need for Resident #1 to be discharged to the emergency room. The IDNS confirmed the documentation he/she reviewed some was illegible and the rest of the review of the progress notes written by the physician that there was no evidence in the clinical record by the physician of what interventions were utilized to assist Resident #1 with his/her behaviors and how and why interventions were not successful and how the facility was unable to meet the needs of Resident #1 at the facility, and sent to the emergency room on 10/11/12. Per interview with the IDNS and the Interim Administrator, on 1/30/13, they confirmed that the expectation is that the resident physician document in the medical record according to the regulatory requirements.	F 202		
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR	F 205		

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205	Continued From page 5 Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide a written bed hold notice to 1 of 10 residents identified and their legal representative (Resident #1) upon emergency discharge from the facility to an acute care facility on 8/5/12 and 10/11/12. The findings include: Per review of the clinical record on 1/23/13, Resident #1 was admitted to the facility on 7/5/11 with diagnoses that include; early onset Alzheimer's, memory loss, and depressive disorder. Per review of the progress notes, Resident #1 has a significant documented history of recurrent episodes of physical and verbal	F 205	<u>F205 483.12(b)(1) &(2) NOTICE OF BED HOLD POLICY BEFORE/UPON TRANSFER</u> Corrective action accomplished for those residents found to have been affected; Resident #1 no longer resides at the facility. How the facility will identify other residents having the potential to be affected and what corrective action has been taken; Residents of the facility who are transferred are identified as having the potential to be affected. In cases of emergency transfer the resident and/or legal representative will be provided with a written notice of the bed hold policy.	
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F 205	Continued From page 6 aggression towards other residents. Per review of the clinical record on 1/23/13, on 8/5/12, Resident #1 was involved in a resident/resident altercation and was discharged from the facility to an acute care facility. The physician order dated 8/5/12 indicates "transfer to CVMC" emergency room. Per record review on 10/11/12, Resident #1 was involved in a resident to resident altercation and discharged from the facility to an acute care center. Per review of the facility Admission agreement signed by Resident #1's responsible party, the agreement indicates that the facility will provide "written notice of the Center's plan to discharge to transfer the patient and the reasons such discharge or transfer was necessary, in accordance with state and federal law." Per interview with the Admissions Coordinator on 1/23/13 and again on 1/30/13, after review of the residents medical record and filed Admission paperwork, he/she was unable to provide documentation that Resident #1 and his/her responsible party received written notification of bed hold for the 8/5/12 discharge and the 10/11/13 discharge from the facility.	F 205	Measures or systemic changes put into place to ensure that the deficient practice will not recur; Licensed nursing staff will be provided with education on providing the resident with a written notice of the emergency transfer/bed hold policy and sending a copy of such with the transfer information. The Admission Assistant and Admission Director will be provided with education on providing a written bed hold notice to the family and/or legal representative within 24 hour of the transfer, or next day that the post office is open. If mailed, it will be done utilizing return receipt.	
F 221 SS=J	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 221	How the corrective actions will be monitored to ensure that the deficient practice does not recur/quality assurance program;	

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221 Continued From page 7

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to assure 1 resident is free from potential physical restraints not required to treat the resident's medical symptoms. (Resident #9) Findings include:

Per record review on 01/28/13, Resident #9, had bi-lateral half side rails that restricted safe movement out of bed during the months of December 2012 and January 2013. The resident's diagnoses include dementia with agitation, a history of multiple falls, a fracture sustained to the left hip in November 2012 and hemiplegia (left side weakness).

Per a fax to the physician dated 01/25/13 at 0800 states "at change of shift 0700 patient found, body on floor with [resident's] neck caught in rail, [resident's] upper body was lifted to get the neck from the rail, neck very red, patient moving head." A nurse progress note dated 01/25/13 at 2:05 PM stated "I had been in to see patient about 0645-0650, [s/he] was asking to get out of bed and told [resident] that LNA's would be in shortly, at that time [resident] was lying facing wall with bell in place and tab alarms attached. At 0700 LNA's yelling for help went to room found patient lying on the floor with [her/his] neck chin caught in the bed rail. [s/he] was not yelling out, asked male nurse to come help me, he lifted [resident] by the shoulders and lay [resident] on the floor, the patient started complaining that the floor was cold and moving [his/her] neck, without difficulty. vital signs and neuro checks done within normal limits. Patient's neck red but no complaining of pain and

F 221

The Executive Director will audit residents who are emergently transferred to ensure that the bed hold notice was provided to the patient and family or legal representative per regulation.

Results of audits reviewed and submitted to the facilities QAPI meeting for trending and tracking with remedial measures initiated as identified.

Person Responsible;

The Executive Director

Date of Correction;

March 1, 2013.
F205 POC accepted 2/20/13 McCullihan RN/PRC

221 483.13(a) RIGHT TO BE
FREE FROM PHYSICAL
RESTRAINTS

Corrective action accomplished for those residents found to have been affected;

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221	Continued From page 8 moving it. got resident up into wheelchair...started 15 minute checks and got order to discontinue the side rails...Doctor faxed and sent back response to check swallowing, breathing and speech, which had already been checked and monitored...most of redness on neck faded, [s/he] has a 6.5 cm long red mark on [his/her] neck." Per review of the care plan dated 12/21/12 for impaired physical mobility related to left hip fracture with repair, history of CVA (stroke) and neuropathy in bilateral feet, the care plan notes the interventions as maximum assist of 2 staff for bed mobility, encourage/assist with repositioning as needed and continue to monitor and re-educate regarding the need for 2 maximum assist with transfer. Per observation on 01/29/13 Resident #9's bed was a low-type bed that had a scoop mattress, the right side of the bed was against the wall and there was a small mattress was on the floor next to the open (left) side of the bed. Per the significant change assessment dated 12/02/12, after the resident sustained a fracture of the left hip in November 2012, Section O (side rail evaluation) notes that the resident has difficulty with balance or poor trunk control and has demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed. Half rails bilaterally were indicated and 'serve as an enabler to promote independence' and an MD order was in place. Per review of the 01/03/13 (re-admission from a hospital stay) notes, the resident arrived via stretcher with assist of two. In addition, in Section D, 'total assist' is needed for personal hygiene, mobility, transfer, and toilet	F 221	Resident #9 does not utilize side rails. The use of the scoop mattress has been assessed by the IDT to determine if it is a restraint. How the facility will identify other residents having the potential to be affected and what corrective action has been taken; Licensed Nursing staff and IDT staff were educated on conducting an evaluation and assessment for residents who have side rails in order to determine the medical necessity/need for side rails and ensure that there is no endangerment of potential entrapment from bed/mattress/side rail gaps. On January 28 and 29 2013, each resident with side rails on their bed was assessed Residents with side rails on their bed were assessed by a licensed nurse with input from the IDT. Each assessment was conducted to determine if the	

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221	Continued From page 9 use. Section E (fall risk) lists level of consciousness/mental status as 'intermittent confusion' and under section H (neurological) as 'lethargic'. Section O (side rail evaluation) notes that the resident has difficulty with balance or poor trunk control and has demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed. Again, half rails bilaterally were indicated and 'serve as an enabler to promote independence' and an MD was order was in place. Per review of the signed physician's orders dated January 2013 there is no order for the side rails. Furthermore, there is no determination if the side rail use was appropriate, given the resident's current history of falls, transfer ability and risk factors such as entrapment. There was also no assessment for the use of a scoop mattress. Per interview with physical therapy (PT) staff on 01/29/12 at 11:00 AM, s/he stated that the resident had plateaued with therapy as the resident is unable/unwilling to work on gaining mobility independence. The PT was unable to answer as to why the bed rails were removed on the day of the incident and to why a scoop mattress was put in place if the resident was assessed as using side rails as enablers for bed mobility. Per interview on 01/29/13 at 3:00 p.m. LNA (Licensed Nursing Assistant) staff stated "[Resident #9's] bottom was on the floor and [her/his] neck was pressed against the bar and because of [her/his] weight [s/he] was unable to move or get up, [s/he] is 50-50 when it comes to moving on [her/his] own but lately we need to do most things for [the resident]". S/he indicated that the resident frequently tries to "wiggle off the bed down past the side rail".	F 221	side rails were needed and if yes, are the side rails a restraint or not. Residents who were assessed to not require side rails or a mobility device, e.g. enabler, for bed positioning or transfer was removed. Side rails used as an assistive device will be replaced with an enabler for bed mobility/transfer. Beds with side rails needing to be replaced by an enabler bar were evaluated for potential entrapment areas, e.g., gaps between side rail and mattress and adjustments made to ensure that there were no gaps. IDT will identify each resident who has a physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Each resident identified will be assessed by the IDT for medical necessity of the use of the device.	
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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/30/2013
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NAME OF PROVIDER OR SUPPLIER DOWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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F 221	Continued From page 10 Per review of the facility's policy for assessing side rails, it notes that the use of side rails requires a complete assessment of the resident's mobility and cognitive functioning to determine the category of use. It further states that side rails used as an enabler for mobility must include the following criteria: a) an evaluation of the ability to move about in bed; b) an evaluation of whether the resident is able to use the side rails(s) in turning; c) a determination that the resident's ability to transfer using the side rail outweighs the risk of falls associated with the use of the side rails. Also, the side rail assessment must include a determination that there is no endangerment or entrapment risk from the gap between side rail and mattress or increased risk of injury from extremities caught in side rails, and states that side rail pads and bolsters are to be used when indicated ensure safety with use of side rails. Per interview on 01/30/13 at 10:57 AM, the DNS confirmed the assessment was not clear to determine if side rails (assistance device) were being used appropriately or if the resident's ability to use side rails outweigh the risk as an accident hazard and that the resident sustained injuries in multiple attempts to exit the bed around the bottom of the side rail during the months of December 2012 and January 2013. Also see F323	F 221	Measures or systemic changes put into place to ensure that the deficient practice will not recur; The facility QA committee reviewed the event involving resident #9 and reviewed the risk versus benefits and discussed alternatives to side rails. The conclusion of the QA committee is that the risks did out-weigh the benefits of side rail usage and has become a "no" side rail usage facility. Education will be provided to staff, residents, and family members on "myths and facts of side rails" including the risks using side rails and alternative interventions which can replace the side rail e.g., enabler bars, trapeze, scoop mattress, low bed/matt on floor, etc.	
F 223 SS=E	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.	F 223	How the corrective actions will be monitored to ensure that the deficient practice does not recur/quality assurance program;	

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NAME OF PROVIDER OR SUPPLIER DOWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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223	Continued From page 11 The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that 8 of 10 residents identified (Residents #1, #2, #3, #4, #5, #6, #7 and #8) were free from verbal, physical, and mental abuse by anyone, including other residents. The findings include: 1. Per review of the clinical record on 1/23/13, Resident #1 was admitted to the facility on 7/5/11 with diagnoses that include; early onset Alzheimer's, memory loss, and depressive disorder. Per review of the progress notes, on 9/22/12, Resident #1 was in the dining room during lunch and "took a roll from [Resident #2], when [Resident #2] said something to [Resident #1], (he/she) started hitting/slapping [Resident #2] on the head several times." Per review of the clinical record on 1/23/13, the progress notes dated on 9/27/12 at 3:56 AM, Resident #1 was "in the main dining room and struck [Resident #2] forcefully in the ear with a spoon." The assessment indicates Resident #2's right ear was pinkish red and Resident #2 complained that it "hurt". Per review of the clinical record on 1/23/13, the progress notes dated on 10/11/12 at 1:19 AM,	F 223	The Director of Nursing and Executive Director will conduct audits to ensure that the facility's no side rail philosophy is maintaining a positive outcome. This will be done at least weekly. Results of the audits will be reviewed and submitted to the facilities QAPI meeting for trending and tracking with remedial measures initiated as identified. Person Responsible; The Director of Nursing Date of Correction; March 1, 2013. <i>FDA POL accepted 2/20/13 mcdwheer/RN/PMC</i> <u>223 483.13(b), 483.13(c)(1)(i)</u> <u>FREE FROM</u> <u>ABUSE/INVOLUNTARY</u> <u>SECLUSION</u> Corrective action accomplished for those residents found to have been affected;	

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223	<p>Continued From page 12</p> <p>"[Resident #1] was observed by another resident's family member, slapping and pushing [Resident #4] to the floor causing [Resident #4] injuries."</p> <p>Per interview with the Interim Director of Nursing (IDNS) and Corporate Clinical Evaluator on 1/23/13 and again on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercations between Resident #1 and Resident #2 and #4. The IDNS confirmed that he/she felt these incidences of resident to resident altercations were abuse.</p> <p>2. Per review of the clinical record on 1/23/13, the clinical record indicates that Resident #2 was re-admitted to facility on 10/2/12, with diagnoses that included persistent mental disorder and psychosis. Per review of the clinical record on 1/23/13, the progress note dated 10/26/12 at 4:38 PM, indicates "Resident very confused, high agitation, screaming at staff and residents, combative, hitting, grabbing, punching, kicking, grabbed the sweatshirt of another resident and almost made the other resident fall." The documentation did not indicate who the other resident was.</p> <p>Per interview with the Interim Director of Nursing (IDNS) and Corporate Clinical Evaluator on 1/23/13 and again on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercations between Resident #2 and another facility resident. The IDNS confirmed that he/she felt these incidences of resident to resident altercations were abuse.</p> <p>3. Per review of the clinical record on 1/23/13, the</p>	F 223	<p>Residents #1 and # 2 no longer reside at the facility.</p> <p>Residents #3, #4, #5, #6, #7, and #8 have been re-assessed by the IDT and their behavior management plans have been revised.</p> <p>How the facility will identify other residents having the potential to be affected and what corrective action has been taken;</p> <p>IDT will identify each resident who has behaviors through walking rounds.</p> <p>Residents identified as having a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in a resident to resident altercation will be reviewed by the IDT plan of care reviewed, physician and psychologist consulted, and a behavior management plan developed.</p>	

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223 Continued From page 13
clinical record indicates that Resident #3 was re-admitted to the facility on 10/9/11 with diagnoses that included; vascular dementia and depressive disorder. Per review of the clinical record on 1/23/13, the progress notes dated 12/10/12 at 7:52 PM indicate that Resident #3 was "sitting in the hallway in [his/her] chair continually yelling out. Another resident came up to [Resident #3] and slapped [him/her] to the side of the head and said, shut up you woke me up."

Per interview with the Interim Director of Nursing (IDNS) and Corporate Clinical Evaluator on 1/23/13 and again on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercations between Resident #3 and another facility resident. The IDNS confirmed that he/she felt these incidences of resident to resident altercations were abuse

4. Per review of the facility's internal investigation and clinical record on 1/29/13, they indicated that on 10/26/12 Resident #8 was admitted to the facility with diagnoses that include unspecified anxiety states, dementia without behavioral disturbances and depressive disorder. The clinical record indicated that on 1/13/13 at 07:51 AM, the housekeeper "observed [Resident #8] hitting his room mate [Resident #5] on the back. The room mate was on the bed of [Resident #8] and would not get off." The progress notes also indicate that Resident #8 was asked why he/she hit Resident #5 and Resident #8 indicated "I hit him because I wanted my bed."

Per interview with the Interim Director of Nursing (IDNS), Interim Administrator and Corporate

F 223

Measures or systemic changes put into place to ensure that the deficient practice will not recur;

A Behavior Management Team will be established, including membership minimally by nursing, social service, activities, rehabilitation, and psychologist. This team will meet weekly and conduct behavior management rounds. The resident's attending physician will be notified of behavior round team assessments.

Cue cards for each resident at risk for altercations have been developed to assist staff with a tool to consult for resident behaviors, triggers, and intervention strategies.

Staff will be provided with education on behavior management and strategies to implement to prevent occurrences of resident to resident altercations/abuse.

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F-223	Continued From page 14 Clinical Evaluator on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercations between Resident #8 and Resident #5. The IDNS confirmed that he/she felt these incidences of resident to resident altercations were abuse. 5. Per review of the facility's internal investigation and clinical record on 1/29/13, they indicated that on 1/14/13, Resident #7 slapped Resident #6 on the left side of the face for no reason. Per the progress note it indicates staff asked Resident #7 if she/he slapped Resident #6 and the resident confirmed he/she did hit Resident #6. Per interview with the Interim Director of Nursing (IDNS), Interim Administrator and Corporate Clinical Evaluator on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercations between Resident #8 and Resident #5. The IDNS confirmed that he/she felt these incidences of resident to resident altercations were abuse.	F 223	How the corrective actions will be monitored to ensure that the deficient practice does not recur/quality assurance program; Residents who are displaying exacerbated behaviors will be identified during Concurrent Review. The resident will be reviewed by the Behavior Management team, a medical record review conducted, plan of care revised as warranted, and interventions implemented. Licensed nursing, social services, or administrative staff will conduct weekly:	
F 224 SS=E	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE 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:	F 224	•direct observation of staff and resident interactions •direct observation of resident and resident interactions for potential resident to resident altercations.	

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224	Continued From page 15 Based on record review and staff interview the facility failed to ensure that 8 of 10 residents identified (Resident #1, #2, #3, #4, #5, #6, #7, #8) with behaviors and personal histories that render them at risk for abusing other residents or being abused by other residents, had interventions developed to prevent occurrences of abuse. The findings include: 1. Per review of the clinical record on 1/23/13, Resident #1 was admitted to the facility on 7/5/11 with diagnoses that include; early onset Alzheimer's, memory loss, and depressive disorder. Per review of the progress notes, on 1/23/13, Resident #1 was in the dining room during lunch on 9/22/12 and took a roll from Resident #2. When Resident #2 said something to Resident #1, he/she started hitting/slapping Resident #2 on the head several times. Per review of the clinical record on 1/23/13, the progress notes dated on 9/27/12 at 3:56 AM indicated, Resident #1 was in the main dining room and struck Resident #2 forcefully in the ear with a spoon. The assessment indicates Resident #2's right ear was pinkish red and Resident #2 complained it "hurt". Per review of the clinical record on 1/23/13, the progress notes dated on 10/11/12 at 1:19 AM, Resident #1 was observed by another resident's family member, slapping and pushing Resident #4 to the floor causing Resident #4 injuries. Per review of the progress notes there was no evidence within the Social Service progress notes	F 224	Social Services will conduct random interviews of residents to monitor that they are not experiencing abuse from anyone. This will be done at least weekly. Results of the audits will be reviewed and submitted to the facilities QAPI meeting for trending and tracking with remedial measures initiated as identified. Person Responsible; Social Services Director Date of Correction; March 1, 2013 <i>F223 POC accepted 2/28/13 McWilliam RN/PMC</i> <u>224 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</u> Corrective action accomplished for those residents found to have been affected;	
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224 Continued From page 16
indicating that Social Services had assessed Resident #1 along with Residents #2, and #4 regarding the incidences of resident to resident altercations where Resident #1 was the aggressor on 9/22, 9/27 or 10/11/12.

Per review of the comprehensive care plans for Residents #1, #2 and #4, there was no evidence that the care plans were reviewed and revised to ensure they met the specific needs and interventions for residents involved in resident to resident altercations and interventions placed after the 9/22, 9/27 and 10/11/12 altercations to ensure that resident to resident abuse did not occur again.

Per interview on 1/23/13, the facility Social Services worker (SSW) confirmed that no assessment had been done by Social Services regarding resident to resident abuse on 9/22/12, 9/27/12 or 10/11/12. The SSW confirmed that he/she did not evaluate Resident #1, #2 or #4 to ensure that the current care plans were sufficiently meeting the specific needs of Resident #1 who was physically abusive towards residents #2 and #4, and the SSW confirmed he/she had not evaluated Residents #2 and #4 to ensure the current care plans was sufficiently meeting the specific needs of Resident #2 and #4 now as victims of abuse. The SSW confirmed that the care plans for Resident's #1, #2 and #4 had not been reviewed and revised to meet the potential and actual needs of residents involved in resident to resident altercation resulting in abuse and interventions placed to ensure that resident to resident abuse did not occur again.

Per interview with the Interim Director of Nursing

F 224

Residents #1 and # 2 no longer reside at the facility.

Residents #3, #4, #5, #6, #7, and #8 have been re-assessed by the IDT and their behavior management plans have been revised.

How the facility will identify other residents having the potential to be affected and what corrective action has been taken;

IDT will identify each resident who has behaviors through walking rounds.

Social Service Director will conduct assessments and ensure that each resident's psychosocial well-being is addressed in their medical record and as part of the IDT plan of care.

Residents who have behaviors and personal histories that render them at risk for abusing other residents or being abused

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224	<p>Continued From page 17</p> <p>(IDNS), and Corporate Clinical Evaluator on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercations between Resident #1 and Resident #2 and #4. The IDNS confirmed that he/she felt these incidences of resident to resident altercations were abuse.</p> <p>2. Per review of the clinical record on 1/23/13, the clinical record indicates that Resident #2 was re-admitted to facility on 10/2/12, with diagnoses that included persistent mental disorder and psychosis. Per review of the clinical record on 1/23/13, the progress note dated 10/26/12 at 4:38 PM, indicates "Resident very confused, high agitation, screaming at staff and residents, combative, hitting, grabbing, punching, kicking, grabbed the sweatshirt of another resident and almost made the other resident fall." The documentation did not indicate who the other resident was.</p> <p>Per review of the progress notes there was no evidence within the Social Service progress notes indicating that Social Services had assessed Resident #2 regarding the incident of a resident to resident altercation where Resident #2 was the aggressor and grabbed another resident on 10/26/12.</p> <p>Per review of the comprehensive care plans for Residents #2 there was no evidence that the care plan was reviewed and revised to ensure the care plan met the specific needs and interventions for Resident #2 who was the aggressor in a resident to resident altercation and interventions placed after the 10/26/12 altercation to ensure that resident to resident abuse did not occur again.</p>	F 224	<p>by other residents will be reviewed by the IDT, plan of care reviewed, physician and psychologist consulted, and a behavior management plan developed.</p> <p>Measures or systemic changes put into place to ensure that the deficient practice will not recur;</p> <p>A Behavior Management Team will be established, including membership minimally by nursing, social service, activities, rehabilitation, and psychologist. This team will meet weekly and conduct behavior management rounds. The resident's attending physician will be notified of behavior round team assessments.</p> <p>Cue cards for each resident at risk for altercations have been developed to assist staff with a tool to consult for resident behaviors, triggers, and intervention strategies.</p>	

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224	Continued From page 18 Per interview on 1/23/13, the facility Social Services worker (SSW) confirmed that no assessment had been done by Social Services regarding resident to resident abuse on 10/26/12. The SSW confirmed that he/she did not evaluate Resident #2 to ensure that the current care plan was sufficiently meeting the specific needs of Resident #2 who was physically abusive towards another resident that could not be identified. The SSW confirmed that the care plan for Resident's #2 had not been reviewed and revised to meet the potential and actual needs of residents involved in resident to resident altercation resulting in potential abuse and interventions placed to ensure that resident to resident abuse did not occur again. Per interview with the Interim Director of Nursing (IDNS) and Corporate Clinical Evaluator on 1/23/12 and on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercations between Resident #2 and another facility resident. The IDNS confirmed that there was no investigation done and no documentation showing who the victim of the 10/26/12 incident was. The IDNS confirmed that he/she felt these incident of resident to resident altercation on 10/26/12 was a potential abuse situation. 3. Per review of the clinical record on 1/23/13, the clinical record indicates that Resident # 3 was re-admitted to the facility on 10/9/11 with diagnoses that included; vascular dementia and depressive disorder. Per review of the clinical record on 1/23/13, the progress notes dated 12/10/12 at 7:52 PM, the notes indicate that	F 224	IDT members will be provided with education on developing behavior management strategies and plans aimed at preventing occurrences of resident to resident altercations/abuse. How the corrective actions will be monitored to ensure that the deficient practice does not recur/quality assurance program; Residents who are displaying exacerbated behaviors will be identified during Concurrent Review. The resident will be reviewed by the Behavior Management team, a medical record review conducted, plan of care revised as warranted, and interventions implemented. The Director of Social Services or Regional Director/Quality Improvement Nurse will audit medical records at least weekly to ensure that intervention strategies are in place and	

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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/30/2013
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NAME OF PROVIDER OR SUPPLIER DOWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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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)	(X6) COMPLETION DATE
224	<p>Continued From page 19</p> <p>Resident #3 was sitting in the hallway in his/her chair continually yelling out. Another resident came up to Resident #3 and slapped him/her to the side of the head and said, shut up you woke me up.</p> <p>Per review of the progress notes there was no evidence within the Social Service progress notes indicating that Social Services had assessed Resident #3 regarding the incident of a resident to resident altercation where Resident #3 was the victim and was slapped to the side of the head by another unidentified resident.</p> <p>Per review of the comprehensive care plans for Residents #3 there was no evidence that the care plans were reviewed and revised to ensure they met the specific needs and interventions for Resident #3 who was the victim in a resident to resident altercation resulting in abuse to Resident #3 and interventions placed after the 12/10/12 altercation to ensure that resident to resident abuse did not occur again.</p> <p>Per interview on 1/23/13, the facility Social Service worker (SSW) confirmed that no assessment had been done by Social Services regarding resident to resident abuse on 12/10/12. The SSW confirmed that he/she did not evaluate Resident #3 to ensure that the current care plan was sufficiently meeting the specific needs of Resident #3 who was the victim of physically abusive behavior by another resident that could not be identified. The SSW confirmed that the care plan for Resident #3 had not been reviewed and revised to meet the potential and actual needs of residents involved in resident to resident altercation resulting in abuse and interventions</p>	F 224	<p>reassessed to prevent occurrences of resident to resident altercations/abuse, and monitor changes that may trigger abusive behavior.</p> <p>Results of the audits will be reviewed and submitted to the facilities QAPI meeting for trending and tracking with remedial measures initiated as identified.</p> <p>Person Responsible; The Executive Director</p> <p>Date of Correction; March 1, 2013</p> <p><i>F224 POC accepted 2/28/13 mcculhan RN/PMC</i></p>	

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NAME OF PROVIDER OR SUPPLIER ROWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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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 224	<p>Continued From page 20</p> <p>placed to ensure that resident to resident abuse did not occur again.</p> <p>Per interview with the Interim Director of Nursing (IDNS) and Corporate Clinical Evaluator on 1/23/13 and again on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercations between Resident #3 and another facility resident. The IDNS confirmed that there was no investigation done and no documentation showing who the aggressor/perpetrator of the 12/10/12 incident was. The IDNS confirmed that he/she felt this incident on 12/10/12 of the resident to resident altercation was abuse.</p> <p>4. Per review of the facility's internal investigation and clinical record on 1/29/13, they indicated that on 10/26/12 Resident #8 was admitted to the facility with diagnoses that included unspecified anxiety states, dementia without behavioral disturbances and depressive disorder. The clinical record indicated that on 1/13/13 at 07:51 AM, the housekeeper observed Resident #8 hitting his room mate (Resident #5) on the back. The room mate was on the bed of Resident #8 and would not get off. The progress notes also indicate that Resident #8 was asked why he/she hit Resident #5 and Resident #8 indicated "I hit him because I wanted my bed."</p> <p>Per review of the progress notes there was no evidence within the Social Service progress notes indicating that Social Services had assessed Resident #8 and Resident #5 regarding the incident of a resident to resident altercation where Resident #8 hit Resident #5 on the back.</p>	F 224		

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224	<p>Continued From page 21</p> <p>Per review of the comprehensive care plans for Residents #5 there was no evidence that the care plans were reviewed and revised to ensure they met the specific needs and interventions for Resident #5 who was the victim in a resident to resident altercation resulting in abuse to Resident #5 and interventions placed after the 1/13/13 altercation until to ensure that resident to resident abuse did not occur again.</p> <p>Per interview on 1/23/13, the facility Social Work worker (SSW) confirmed that no assessment had been done by Social Services regarding resident to resident abuse on 1/13/13. The SSW confirmed that he/she did not evaluate Resident #5 to ensure that the current care plan was sufficiently meeting the specific needs of Resident #5 who was the victim of physically abusive. The SSW confirmed that the care plan for Residents #5 and Resident #8 had not been reviewed and revised to meet the potential and actual needs of residents involved in resident to resident altercation resulting in abuse and interventions placed to ensure that resident to resident abuse did not occur again.</p> <p>Per interview with the Interim Director of Nursing (IDNS), Interim Administrator and Corporate Clinical Evaluator on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercations between Resident #8 and Resident #5 on 1/13/13. The IDNS confirmed that he/she felt this incident of resident to resident altercation was abuse. Per interview with the Interim Administrator and IDNS, they confirmed the care plans were not reviewed and revised to ensure the care plans met the needs of Resident #5 and Resident #8 until</p>	F 224		

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F 224	<p>Continued From page 22</p> <p>1/25/13 which was 12 days after the abuse. The Interim Administrator confirmed after he/she reviewed the progress notes and care plan and confirmed that Resident #5 had not been moved from the bedroom after the altercation and placed in a new room until 1/14/13. The Interim Administrator indicated that the resident was monitored to ensure safety but was unable to verbalize how the resident was monitored or show any documentation that Resident #5 was protected from further abuse until the room change on 1/14/13.</p> <p>5. Per review of the facilities internal investigation and clinical record on 1/29/13, they indicated that on 1/14/13, Resident #7 slapped Resident #6 on the left side of the face for no reason. Per the progress note it indicates staff asked Resident #7 if she/he slapped Resident #6 and the resident confirmed he/she did hit Resident #6.</p> <p>Per review of the progress notes there was no evidence within the Social Service progress notes indicating that Social Services had assessed Resident #6 and Resident # 7 regarding the incident of a resident to resident altercation where Resident #7 slapped Resident #6 on the left side of the face.</p> <p>Per review of the comprehensive care plans for Residents #6 there was no evidence that the care plan was reviewed and revised after the 1/14/13 incident until 1/25/13 to ensure the care plan met the specific needs and interventions for Resident #6 who was the victim in a resident to resident altercation resulting in abuse</p> <p>Per review of the comprehensive care plans for</p>	F 224		

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NAME OF PROVIDER OR SUPPLIER DOWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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F 225	<p>Continued From page 24</p> <p>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 thoroughly investigate allegations of potential abuse, prevent further potential abuse while the investigation is in progress, and failed to report to the required state agency incidences of suspected abuse for 8 of 10 residents identified (Resident #1, 2, 3, 4, 5, 6, 7, 8). The facility also failed to ensure that those employees who have direct contact with facility residents have had the appropriate background checks prior to starting employment. The findings include:</p> <p>1. Per review of the clinical record on 1/23/13, Resident #1 was admitted to the facility on 7/5/11</p>	F 225	<p>The required background checks were immediately obtained (January 30, 2013) for those employees identified in this 2567.</p> <p>How the facility will identify other residents having the potential to be affected and what corrective action has been taken;</p> <p>Residents residing at the facility have the potential to be affected.</p> <p>Files of staff currently employed at the facility will be audited to determine if each has the required background checks. If found to not have the required backgrounds checks in their file; the employee will not be scheduled for work until such documentation has been obtained.</p> <p>Incidences of suspected abuse which have occurred since January 30, 2013 will be</p>	

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F 225	<p>Continued From page 25</p> <p>with diagnoses that include: early onset Alzheimer's, memory loss, and depressive disorder.</p> <p>Per review of the progress notes, on 1/23/13, Resident #1 was in the dining room during lunch on 9/22/12 and took a roll from Resident #2. When Resident #2 said something to Resident #1, he/she started hitting/slapping Resident #2 on the head several times.</p> <p>Per review of the clinical record on 1/23/13, the progress notes dated on 9/27/12 at 3:56 AM indicated, Resident #1 was in the main dining room and struck Resident #2 forcefully in the ear with a spoon. The assessment indicates Resident #2's right ear was pinkish red and Resident #2 complained it "hurt".</p> <p>Per review of the clinical record on 1/23/13, the progress notes dated on 10/11/12 at 1:19 AM, state Resident #1 was observed by another resident's family member, slapping and pushing Resident #4 to the floor causing Resident #4 injuries.</p> <p>Per interview with the Interim Director of Nursing (IDNS), and Corporate Clinical Evaluator on 1/23/13, and again on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercations between Resident #1 and Resident #2 and #4. The IDNS confirmed that no thorough internal investigation had been conducted regarding these incidents of abuse. The IDNS indicated that the previous Administrator who left in November 2012, had instructed the IDNS that because the residents were cognitively impaired, an investigation did not</p>	F 225	<p>audited by the Regional Director/Quality Improvement Nurse to identify areas needing corrective action related to compliance with this deficiency. The Director of Nurses and Executive Director will be responsible for making corrections as identified.</p> <p>Measures or systemic changes put into place to ensure that the deficient practice will not recur;</p> <p>Education will be provided to the facility leadership on ensuring that abuse policies and procedures are followed.</p> <p>The Executive Director will hold general staff meetings to communicate facility policies and expected actions.</p> <p>Staff will be re-educated on abuse policies and procedures with particular attention to resident to resident altercations/abuse, Executive Director notification requirements when there is</p>	

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225	<p>Continued From page 26</p> <p>have to be done and the facility did not have to notify the appropriate state agencies. The IDNS on 1/23/13 in interview confirmed that as a Registered Nurse he/she is a mandated reporter and must notify the appropriate agencies when there is a reasonable assumption that abuse may have occurred. The IDNS confirmed that he/she felt these incidences of resident to resident altercations were abuse</p> <p>2. Per review of the clinical record on 1/23/13, the clinical record indicates that Resident #2 was re-admitted to facility on 10/2/12, with diagnoses that included persistent mental disorder and psychosis. Per review of the clinical record on 1/23/13, the progress note dated 10/26/12 at 4:38 PM, indicates "Resident very confused, high agitation, screaming at staff and residents, combative, hitting, grabbing, punching, kicking, grabbed the sweatshirt of another resident and almost made the other resident fall". The documentation did not indicate who the other resident was.</p> <p>Per review of the progress notes there was no evidence within the Social Service progress notes indicating that Social Services had assessed Resident #2 regarding the incident of a resident to resident altercation where Resident #2 was the aggressor and grabbed another resident on 10/26/12.</p> <p>Per interview with the Interim Director of Nursing (IDNS) and Corporate Clinical Evaluator on 1/23/12 and on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercations between Resident #2 and another facility resident. The IDNS confirmed that</p>	F 225	<p>suspected abuse, steps to take to prevent further potential abuse while the investigation is in progress, completing thorough investigations, and administrator review of the results of the investigation for corrective action.</p> <p>How the corrective actions will be monitored to ensure that the deficient practice does not recur/quality assurance program;</p> <p>The Regional Director/Quality Improvement Nurse will conduct audits of incidences of suspected/confirmed abuse including resident to resident altercations to ensure that such incidences are reported as required, investigated thoroughly, and the results of such investigations are reviewed by the Administrator.</p> <p>The Business Office Manager will conduct audits for new hires to ensure that background checks have been completed.</p>	

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F 225 Continued From page 27

there was no thorough investigation done and no documentation identifying who the victim of the 10/26/12 incident was. The IDNS indicated that the previous Administrator who left in November 2012, had instructed the IDNS that because the residents were cognitively impaired, an investigation did not have to be done and the facility did not have to notify the appropriate state agencies. The IDNS on 1/23/13 in interview confirmed that as a Registered Nurse he/she is a mandated reporter and must notify the appropriate agencies when there is a reasonable assumption that abuse may have occurred.

3. Per review of the clinical record on 1/23/13, the clinical record indicates that Resident #3 was re-admitted to the facility on 10/9/11 with diagnoses that included, vascular dementia and depressive disorder. Per review of the clinical record on 1/23/13, the progress notes dated 12/10/12 at 7:52 PM, the notes indicate that Resident #3 was sitting in the hallway in his/her chair continually yelling out. Another resident came up to Resident #3 and slapped him/her to the side of the head and said, shut up you woke me up.

Per interview with the Interim Director of Nursing (IDNS) and Corporate Clinical Evaluator on 1/23/13 and again on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercations between Resident #3 and another facility resident. The IDNS confirmed that there was no thorough investigation done and no documentation showing who the victim of the 12/10/12 incident was. On 1/30/13, the IDNS and Interim Administrator confirmed that no investigation had

F 225

The results of the audits will be reviewed and submitted to the facilities QAPI meeting for trending and tracking with remedial measures initiated as identified.

Person Responsible;

The Executive Director

Date of Correction;

March 1, 2013

*F225 POC accepted 2/28/13
McLellan R/W/PMC*

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F 225	<p>Continued From page 28</p> <p>been conducted and the incident had not been called into the required state agency because the IDNS and Interim Administrator indicated they believed a report did not have to be done or call placed reporting suspected abuse between confused residents. The IDNS confirmed that he/she felt this incident on 12/10/12 of the resident to resident altercation was abuse. The IDNS on 1/23/13 in interview confirmed that as a Registered Nurse he/she is a mandated reporter and must notify the appropriate agencies when there is a reasonable assumption that abuse may have occurred.</p> <p>4. Per review of the facilities internal investigation and clinical record on 1/29/13, they indicated that on 10/26/12 Resident #8 was admitted to the facility with diagnoses that included unspecified anxiety states, dementia without behavioral disturbances and depressive disorder. The clinical record indicated that on 1/13/13 at 07:51 AM, the housekeeper observed Resident #8 hitting his room mate (Resident #5) on the back. The room mate was on the bed of Resident #8 and would not get off. The progress notes also indicates that Resident #8 was asked why he/she hit Resident #5 and Resident #8 indicated "I hit him because I wanted my bed."</p> <p>Per interview with the Interim Director of Nursing (IDNS), Interim Administrator and Corporate Clinical Evaluator on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercations between Resident #8 and Resident #5 on 1/13/13. Per interview with the Interim Administrator and IDNS, they confirmed that an internal investigation was completed and faxed to the required state agency</p>	F 225		

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F 225	<p>Continued From page 29</p> <p>on 1/25/13, which was 12 days after the incident of abuse. The IDNS and Interim Administrator confirmed that they had not reported the incident per regulations because they believed that incidents of resident to resident altercations and abuse did not have to be reported if the residents involved were cognitively impaired. The IDNS confirmed that he/she felt this incident of resident to resident altercation was abuse. The IDNS on 1/23/13 in interview confirmed that as a Registered Nurse he/she is a mandated reporter and must notify the appropriate agencies when there is a reasonable assumption that abuse may have occurred.</p> <p>5. Per review of the facilities internal investigation and clinical record on 1/29/13, they indicated that on 1/14/13, Resident #7 slapped Resident #6 on the left side of the face for no reason. Per the progress note it indicates staff asked Resident #7 if she/he slapped Resident #6 and the resident confirmed he/she did hit Resident #6.</p> <p>Per interview with the Interim Director of Nursing (IDNS), Interim Administrator and Corporate Clinical Evaluator on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercation between Resident #7 and Resident #6 on 1/14/13. The IDNS confirmed that he/she felt this incident of resident to resident altercation were abuse. Per interview with the Interim Administrator and IDNS on 1/30/13, they confirmed that an internal investigation was completed and faxed to the required state agency on 1/25/13, which was 11 days after the incident of abuse. The IDNS and Interim Administrator confirmed that they had not reported the incident per regulations because</p>	F 225		
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F 225	Continued From page 30 they believed that incidents of resident to resident altercations and abuse did not have to be reported if the residents involved were cognitively impaired. The IDNS confirmed that he/she felt this incident of resident to resident altercation was abuse. The IDNS on 1/23/13 in interview confirmed that as a Registered Nurse he/she is a mandated reporter and must notify the appropriate agencies when there is a reasonable assumption that abuse may have occurred 6. Per review of the facility documentation on 1/30/13, during the extended survey process, it was identified that there was no evidence that the required background checks (VCIC [Vermont Criminal Information Center], OIG [Office of the Inspector General] and APS [Adult Abuse Registry]) were conducted for the contracted Interim Director of Nursing (IDNS) who had direct contact with facility residents, prior to his/her start date in September 2012. Per interview with the Corporate Clinical Evaluator on 1/30/13 at approximately 3:00 PM, he/she reviewed the employee file provided by the facility and confirmed that there were none of the required background checks conducted for the contracted IDNS as per requirements. 7. On 1/30/13 at approximately 3:10 PM, the facility was asked to provide all the background checks for all contracted employees used by the facility that have direct care with the residents. At approximately, 5:30-6:00 PM the Interim Administrator provided the obtained background checks for all contracted employees of the facility that provide direct care with the residents.	F 225		

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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/30/2013
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NAME OF PROVIDER OR SUPPLIER DOWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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(4) 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)	(X4) COMPLETION DATE
225	Continued From page 31 Per review of the provided documents on 1/30/13 at approximately 6:00 PM, it was identified upon direct observation of all provided documents, that 17 contracted employees that have direct contact with the facility residents did not have any of the required background checks (VCIC, APS, and OIG) and the facility provided documents for 6 contracted employees that did not contain all the required checks completed and 3 contracted employees whose VCIC check was requested on 1/30/13, the last date of the survey. Per interview with the Interim Administrator on 1/30/13 at approximately 6:30 PM, he/she indicated that the person that was contacted at another location to send over the paperwork for the requested contract employees only had provided what was reviewed. The Interim Administrator when asked was also unable to confirm that the 3 contracted employees that the facility had requested VCIC checks on 1/30/13 had been hired on 1/30/13. Per interview with the Interim Administrator, he/she confirmed that he/she was aware the background checks were to be performed prior to a contracted employee starting work. The Interim Administrator also confirmed on 1/30/13 that the facility's current system to ensure that background checks were completed by the human resources employee had not been effective and no checking was done to ensure all checks were done appropriately when the human resources employee left the facility a few weeks prior.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit	F 226		

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NAME OF PROVIDER OR SUPPLIER HOWAN COURT HEALTH & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641	

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F 226	<p>Continued From page 32 mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed implement written policies and procedures that prohibit mistreatment, neglect and abuse of 8 of 10 residents identified (Resident #1, #2, #3, #4, #5, #6, #7, #8.). The findings include:</p> <p>1. Per review of the clinical record on 1/23/13, Resident #1 was admitted to the facility on 7/5/11 with diagnosis that include; early onset Alzheimer's, memory loss, and depressive disorder.</p> <p>Per review of the progress notes, on 1/23/13, Resident #1 was in the dining room during lunch on 9/22/12 and took a roll from Resident #2. When Resident #2 said something to Resident #1, he/she started hitting/slapping Resident #2 on the head several times.</p> <p>Per review of the clinical record on 1/23/13, the progress notes dated on 9/27/12 at 3:56 AM indicated, Resident #1 was in the main dining room and struck Resident #2 forcefully in the ear with a spoon. The assessment indicates Resident #2's right ear was pinkish red and Resident #2 complained it "hurt".</p> <p>Per review of the clinical record on 1/23/13, the progress notes dated on 10/11/12 at 1:19 AM, Resident #1 was observed by another resident's</p>	F 226	<p><u>226 483.13(c)</u> <u>DEVELOPMENT/IMPLEMENT</u> <u>ABUSE/NEGLECT, ETC POLICIES</u></p> <p>How the facility will identify other residents having the potential to be affected and what corrective action has been taken;</p> <p>Residents residing at the facility have the potential to be affected.</p> <p>The Executive Director will hold general staff meetings to communicate facility policies and expected actions.</p> <p>Measures or systemic changes put into place to ensure that the deficient practice will not recur;</p> <p>Education will be provided to the facility leadership on ensuring that abuse policies and procedures are followed.</p> <p>Staff will be re-educated on abuse policies and procedures.</p>	

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F 226	<p>Continued From page 33</p> <p>family member, slapping and pushing Resident #4 to the floor causing Resident #4 injuries.</p> <p>Per review of the facility written policy and procedure provided by the facility and titled; "Abuse Prevention Program", it indicates that, "comprehensive policies and procedures have been developed to aid our facility in preventing abuse and govern at a minimum: identification of occurrences and patterns of potential mistreatment/abuse, the protection of residents during abuse investigations, timely, through investigations of all reports and allegations of abuse, the reporting and filing of accurate documents relative to incidents of abuse, and the implementation of changes to prevent future occurrences of abuse."</p> <p>Per review of the Corporate Compliance policy and procedure provided by the facility as part of their current abuse prevention policy and titled "Elder Abuse Act", it indicates that the "centers will report suspected crimes against residents. All crimes or suspected crimes that do not constitute serious injury will be reported within 24 hours. Revera owners, operators, administrators, employees, managers, agents and contractors must report". The policy also indicates what to report, as most crimes under the Elder Abuse Act will fall under the general guidelines of abuse or theft, both of which must already be reported. The policy also indicates that "All crimes involving residents should be reported regardless of whether either resident has dementia".</p> <p>Per interview with the Interim Director of Nursing (IDNS), and Corporate Clinical Evaluator on 1/23/13, and again on 1/30/13, the IDNS</p>	F 226	<p>How the corrective actions will be monitored to ensure that the deficient practice does not recur/quality assurance program;</p> <p>Social Services, administrative staff or regional operations/clinical staff will conduct, on a weekly basis: Direct observation of staff and resident interactions and random interviews of staff to ensure that abuse policies and procedures are followed.</p> <p>Social Services will conduct random interviews of residents to monitor that they are not experiencing abuse from anyone.</p> <p>Results of the audits will be reviewed and submitted to the facilities QAPI meeting for trending and tracking with remedial measures initiated as identified.</p>	
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F 226	<p>Continued From page 34</p> <p>confirmed that he/she was aware of the resident to resident abuse and altercations between Resident #1 and Resident #2 and #4. The IDNS confirmed that no thorough internal investigation had been conducted regarding these incidents of abuse. The IDNS indicated that the previous Administrator who left in November 2012, had instructed the IDNS that because the residents were cognitively impaired, an investigation did not have to be done and the facility did not have to notify the appropriate state agencies. The IDNS on 1/23/13 in interview confirmed that as a Registered Nurse he/she is a mandated reporter and must notify the appropriate agencies when there is a reasonable assumption that abuse may have occurred. The IDNS confirmed that he/she felt these incidences of resident to resident altercations were abuse</p> <p>2. Per review of the clinical record on 1/23/13, the clinical record indicates that Resident #2 was re-admitted to facility on 10/2/12, with diagnoses that included persistent mental disorder and psychosis. Per review of the clinical record on 1/23/13, the progress note dated 10/26/12 at 4:38 PM, indicates "Resident very confused, high agitation, screaming at staff and residents, combative, hitting, grabbing, punching, kicking, grabbed the sweatshirt of another resident and almost made the other resident fall." The documentation did not indicate who the other resident was.</p> <p>Per review of the progress notes there was no evidence within the Social Service progress notes indicating that Social Services had assessed Resident #2 regarding the incident of a resident to resident altercation where Resident #2 was the</p>	F 226	<p>Person Responsible;</p> <p>The Executive Director</p> <p>Date of Correction;</p> <p>March 1, 2013</p> <p><i>F226 POC accepted 2/28/13 McWhin R/J/PMC</i></p>	

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F 226	Continued From page 35 aggressor and grabbed another resident on 10/26/12. Per interview with the Interim Director of Nursing (IDNS) and Corporate Clinical Evaluator on 1/23/12 and on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercations between Resident #2 and another facility resident. The IDNS confirmed that there was no thorough investigation done and no documentation identifying who the victim of the 10/26/12 incident was. The IDNS indicated that the previous Administrator who left in November 2012, had instructed the IDNS that because the residents were cognitively impaired, an investigation did not have to be done and the facility did not have to notify the appropriate state agencies. The IDNS on 1/23/13 in interview confirmed that as a Registered Nurse he/she is a mandated reporter and must notify the appropriate agencies when there is a reasonable assumption that abuse may have occurred. 3. Per review of the clinical record on 1/23/13, the clinical record indicates that Resident # 3 was re-admitted to the facility on 10/9/11 with diagnoses that included; vascular dementia and depressive disorder. Per review of the clinical record on 1/23/13, the progress notes dated 12/10/12 at 7:52 PM, the notes indicate that Resident #3 was sitting in the hallway in his/her chair continually yelling out. Another resident came up to Resident #3 and slapped him/her to the side of the head and said, shut up you woke me up. Per interview with the Interim Director of Nursing (IDNS) and Corporate Clinical Evaluator on	F 226		

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F 226	Continued From page 36 1/23/13 and again on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercation between Resident #3 and another facility resident. The IDNS confirmed that there was no thorough investigation done and no documentation showing who the victim of the 12/10/12 incident was. On 1/30/13, the IDNS and Interim Administrator confirmed that no investigation had been conducted and the incident had not been called into the required state agency because the IDNS and Interim Administrator indicated they believed a report did not have to be done or call placed reporting suspected abuse between confused residents. The IDNS confirmed that he/she felt this incident on 12/10/12 of the resident to resident altercation was abuse. The IDNS on 1/23/13 in interview confirmed that as a Registered Nurse he/she is a mandated reporter and must notify the appropriate agencies when there is a reasonable assumption that abuse may have occurred. 4. Per review of the facilities internal investigation and clinical record on 1/29/13, they indicated that on 10/26/12 Resident #8 was admitted to the facility with diagnoses that included unspecified anxiety states, dementia without behavioral disturbances and depressive disorder. The clinical record indicated that on 1/13/13 at 07:51 AM, the housekeeper observed Resident #8 hitting his room mate (Resident #5) on the back. The room mate was on the bed of Resident #8 and would not get off. The progress notes also indicates that Resident #8 was asked why he/she hit Resident #5 and Resident #8 indicated "I hit him because I wanted my bed."	F 226		

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F 226	Continued From page 37 Per interview with the Interim Director of Nursing (IDNS), Interim Administrator and Corporate Clinical Evaluator on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercations between Resident #8 and Resident #5 on 1/13/13. Per interview with the Interim Administrator and IDNS, they confirmed that an internal investigation was completed and faxed to the required state agency on 1/25/13, which was 12 days after the incident of abuse. The IDNS and Interim Administrator confirmed that they had not reported the incident per regulations because they believed that incidents of resident to resident altercations and abuse did not have to be reported if the residents involved were cognitively impaired. The IDNS confirmed that he/she felt this incident of resident to resident altercation was abuse. The IDNS on 1/23/13 in interview confirmed that as a Registered Nurse he/she is a mandated reporter and must notify the appropriate agencies when there is a reasonable assumption that abuse may have occurred. 5. Per review of the facilities internal investigation and clinical record on 1/29/13, they indicated that on 1/14/13, Resident #7 slaps Resident #6 on the left side of the face for no reason. Per the progress note it indicates staff asked Resident #7 if she/he slapped Resident #6 and the resident confirmed he/she did hit Resident #6. Per interview with the Interim Director of Nursing (IDNS), Interim Administrator and Corporate Clinical Evaluator on 1/30/13, the IDNS confirmed that he/she was aware of the resident to resident abuse and altercation between Resident #6 and Resident #7 on 1/14/13. The	F 226		

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F 226	<p>Continued From page 38</p> <p>IDNS confirmed that he/she felt this incident of resident to resident altercation were abuse. Per interview with the Interim Administrator and IDNS on 1/30/13, they confirmed that an internal investigation was completed and faxed to the required state agency on 1/25/13, which was 11 days after the incident of abuse. The IDNS and Interim Administrator confirmed that they had not reported the incident per regulations because they believed that incidents of resident to resident altercations and abuse did not have to be reported if the residents involved were cognitively impaired. The IDNS confirmed that he/she felt this incident of resident to resident altercation was abuse. The IDNS on 1/23/13 in interview confirmed that as a Registered Nurse he/she is a mandated reporter and must notify the appropriate agencies when there is a reasonable assumption that abuse may have occurred.</p> <p>6. Per review of the facility documentation on 1/30/13, during the extended survey process, it was identified that there was no evidence that the required background checks, (VCIC, OIG and APS) were conducted for the contracted Interim Director of Nursing (IDNS) prior to his/her start date in September 2012.</p> <p>Per interview with the Corporate Clinical Evaluator on 1/30/13 at approximately 3:00 PM, he/she reviewed the employee file provided by the facility and confirmed that there were none of the required background checks conducted for the contracted IDNS as per requirements.</p> <p>On 1/30/13 at approximately 3:10 PM, the facility was asked to provide all the background checks for all contracted employees used by the facility</p>	F 226		

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F 226	Continued From page 39 that have direct care with the residents. At approximately, 5:30-6:00 PM the Interim Administrator provided the obtained background checks for all contracted employees of the facility that provide direct care with the residents. Per review of the provided documents on 1/30/13 at approximately 6:00 PM, it was identified upon direct observation of all provided documents that 17 contracted employees did not have any of the required background checks (VCIC, APS, and OIG) and the facility provided documents for 6 contracted employees that did not contain all the required checks completed and 3 contracted employees whose VCIC check was requested on 1/30/13, the last date of the survey. Per review of the facility policy and procedure provided by the facility and reviewed on 1/30/13, titled: "Abuse Prevention Program", it indicates that "the facility conducts employee background checks and will not knowingly employ any individual who has been convicted of abusing, neglecting or mistreating individuals and protocols for conducting employment background checks." Per interview with the Interim Administrator on 1/30/13 at approximately 6:30 PM, he/she indicated that the person that was contacted at another location to send over the paperwork for the requested contract employees only had provided what was reviewed. The Interim Administrator when asked was also unable to confirm that the 3 contracted employees that the facility had requested VCIC checks on 1/30/13 had been hired on 1/30/13. Per interview with the Interim Administrator, he/she confirmed that he/she was aware the background checks were	F 226		

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F 226	Continued From page 40 to be performed prior to a contracted employee starting work. The Interim Administrator also confirmed on 1/30/13 that the facilities current system to ensure that background checks were completed by the human resources employee had not been effective and no checking was done to ensure all checks were done appropriately when the human resources employee left the facility a few weeks prior.	F 226		
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE 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 8 of 10 residents identified (Resident's #1, #2, #3, #4, #5, #6, #7, and #8). The findings include: 1. Per review of the clinical record on 1/23/13, Resident #1 was admitted to the facility on 7/5/11 with diagnoses that include; early onset Alzheimer's, memory loss, and depressive disorder. Per review of the progress notes, on 1/23/13, Resident #1 was in the dining room during lunch on 9/22/12 and took a roll from Resident #2.	F 250	<u>250 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICES</u> Corrective action accomplished for those residents found to have been affected; Residents #1 and # 2 no longer reside at the facility. Residents #3, #4, #5, #6, #7, and #8 have been re-assessed by Social Services to identify and address their needs related to behavior management. How the facility will identify other residents having the potential to be affected and what corrective action has been taken;	

Feb 11 2013 07:44PM Fax 8022412348

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F 250	<p>Continued From page 41</p> <p>When Resident #2 said something to Resident #1, he/she started hitting/slapping Resident #2 on the head several times.</p> <p>Per review of the clinical record on 1/23/13, the progress notes dated on 9/27/12 at 3:56 AM indicated, Resident #1 was in the main dining room and struck Resident #2 forcefully in the ear with a spoon. The assessment indicates Resident #2's right ear pinkish red and Resident #2 complained it "hurt".</p> <p>Per review of the clinical record on 1/23/13, the progress notes dated on 10/11/12 at 1:19 AM, state that Resident #1 was observed by another resident's family member, slapping and pushing Resident #4 to the floor causing Resident #4 injuries.</p> <p>Per review of the progress notes there was no evidence within the Social Service progress notes indicating that Social Services had assessed Resident #1, #2 or #4 regarding the incident of resident to resident altercations where Resident #1 was the aggressor and Resident #2 and #4 were the victims of abuse on 9/22/12, 9/27/12 and 10/11/12.</p> <p>Per interview on 1/23/13, the facility Social Service worker (SSW) confirmed that no assessment had been done by Social Services regarding resident to resident abuse on 9/22/12, 9/27 and 10/11/12. The SSW confirmed that he/she did not evaluate Residents #1, #2, and #4 to ensure that the current care plan was sufficiently meeting the specific needs of Resident #1 being the aggressor and Residents #2 and #4 being the victims of abuse. The SSW</p>	F 250	<p>IDT will identify each resident who has behaviors through walking rounds.</p> <p>Residents who have behaviors and personal histories that render them at risk for abusing other residents or being abused by other residents will be reviewed by the IDT, plan of care reviewed, physician and psychologist consulted, and a behavior management plan developed.</p> <p>Incidences of resident to resident altercations/abuse which have occurred since January 30, 2013 will be audited by the Regional Director/Quality Improvement Nurse to identify areas needing corrective action related to compliance with this deficiency. The Director of Social Services will be responsible for making corrections as identified.</p>	

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NAME OF PROVIDER OR SUPPLIER DOWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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KEY 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 250	<p>Continued From page 42</p> <p>confirmed that the care plans for Residents #1, #2 and #4 had not been reviewed and revised to meet the potential and actual needs of a resident involved in resident to resident altercation resulting in abuse and interventions placed to ensure that resident to resident abuse did not occur again.</p> <p>Per interview with the Interim Director of Nursing (IDNS), and Corporate Clinical Evaluator on 1/23/13, The IDNS confirmed that he/she felt these incidences of resident to resident altercations were abuse and the facility expectation is that the SSW would address the needs of residents involved in resident to resident altercations.</p> <p>2. Per review of the clinical record on 1/23/13, it indicates that Resident #2 was re-admitted to the facility on 10/2/12, with diagnoses that include persistent mental disorder and psychosis. Per review of the clinical record on 1/23/13, the progress note dated 10/26/12 at 4:38 PM, indicates "Resident very confused, high agitation, screaming at staff and residents, combative, hitting, grabbing, punching, kicking, grabbed the sweatshirt of another resident and almost made the other resident fall". The documentation did not indicate who the other resident was.</p> <p>Per review of the progress notes on 1/23/13 there was no evidence within the Social Service progress notes indicating that Social Services had assessed Resident #2 regarding the incident of resident to resident altercation where Resident #2 was the aggressor and a unidentified resident was the potential victim on 10/26/12.</p>	F 250	<p>Measures or systemic changes put into place to ensure that the deficient practice will not recur;</p> <p>During the weekly behavior management rounds, the team will review residents involved in resident to resident altercations/abuse. The resident's attending physician will be notified of behavior round team assessments.</p> <p>Social Service staff will be provided with education on addressing and documenting the needs of resident involved in resident to resident altercations/abuse.</p> <p>Social Service Director will conduct assessments and ensure that each resident's psychosocial well-being is addressed in their medical record and as part of the IDT plan of care.</p>	

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NAME OF PROVIDER OR SUPPLIER DOWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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(4) 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)	(5) COMPLETION DATE
250	<p>Continued From page 43</p> <p>Per interview on 1/23/13, the facility Social Service worker (SSW), he/she confirmed that no assessment had been done by Social Services regarding the resident to resident altercation and potential abuse on 10/26/12. The SSW confirmed that he/she did not evaluate Resident #2 to ensure that the current care plan was sufficiently meeting the specific needs of Resident #2 being the aggressor. The SSW was not able to identify who the potential victim was in the altercation documented in the medical record on 10/26/12. The SSW confirmed that the care plans for Resident #2 had not been reviewed and revised to meet the potential and actual needs of a resident involved in resident to resident altercation and interventions placed to ensure that resident to resident altercation did not occur again.</p> <p>Per interview with the Interim Director of Nursing (IDNS), and Corporate Clinical Evaluator on 1/23/13, the IDNS confirmed that he/she felt these incidences of resident to resident altercations were abuse and the facility expectation is that the SSW would address the needs of residents involved in resident to resident altercations. The IDNS and Corporate Clinical Evaluator were unable to identify the other resident involved in the documented altercation with Resident #2 on 10/26/12.</p> <p>3. Per review of the clinical record on 1/23/13, the clinical record indicates that Resident # 3 was re-admitted to the facility on 10/9/11 with diagnoses that included; vascular dementia and depressive disorder. Per review of the clinical record on 1/23/13, the progress notes dated 12/10/12 at 7:52 PM, indicate that Resident #3</p>	F 250	<p>How the corrective actions will be monitored to ensure that the deficient practice does not recur/quality assurance program;</p> <p>Residents who are displaying exacerbated behaviors will be identified during Concurrent Review. The resident will be reviewed by the Behavior Management team, a medical record review conducted, plan of care revised as warranted, and interventions implemented.</p> <p>The Director of Social Services or Regional Director/Quality Improvement Nurse will audit medical records at least weekly to ensure that residents who are involved in resident to resident altercations/abuse are assessed by Social Services to identify and address their needs related to the altercation/abuse.</p>	

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NAME OF PROVIDER OR SUPPLIER DOWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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(4) 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 250	<p>Continued From page 44</p> <p>was sitting in the hallway in his/her chair continually yelling out. Another resident came up to Resident #3 and slapped him/her to the side of the head and said, shul up you woke me up.</p> <p>Per review of the progress notes on 1/23/13 there was no evidence within the Social Service progress notes indicating that Social Services had assessed Resident #3 regarding the incident of resident to resident altercation where Resident #3 was the victim of abuse by an unidentified resident on 12/10/12.</p> <p>Per interview on 1/23/13, the facility Social Service worker (SSW) confirmed that no assessment had been done by Social Services regarding the resident to resident altercation and abuse on 12/10/12. The SSW confirmed that he/she did not evaluate Resident #3 to ensure that the current care plan was sufficiently meeting the specific needs of Resident #3 who was the victim of abuse on 12/10/12 by another resident. The SSW was not able to identify who the potential aggressor in the altercation documented in the medical record on 12/10/12. The SSW confirmed that the care plans for Resident #3 had not been reviewed and revised to meet the potential and actual needs of a resident involved in resident to resident altercation and the victim of abuse and interventions placed to ensure that resident to resident altercation and abuse did not occur again.</p> <p>Per interview with the Interim Director of Nursing (IDNS), and Corporate Clinical Evaluator on 1/23/13, The IDNS confirmed that he/she felt the incident on 12/10/12 where there was a resident to resident altercation and was considered abuse.</p>	F 250	<p>Results of the audits will be reviewed and submitted to the facilities QAPI meeting for trending and tracking with remedial measures initiated as identified.</p> <p>Person Responsible;</p> <p>Social Services Director</p> <p>Date of compliance;</p> <p>March 1, 2013</p> <p><i>FASD POC accepted 2/28/13 mcwihan RML pnc</i></p>	

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(4) 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 250	<p>Continued From page 45</p> <p>The IDNS confirmed that the facility expectation is that the SSW would address the needs of residents involved in resident to resident altercations. The IDNS and Corporate Clinical Evaluator were unable to identify the other resident involved in the documented altercation with Resident #2 on 12/10/12.</p> <p>4. Per review of the facility's internal investigation and clinical record on 1/29/13, they indicated that on 10/26/12 Resident #8 was admitted to the facility with diagnoses that included unspecified anxiety states, dementia without behavioral disturbances and depressive disorder. The clinical record indicated that on 1/13/13 at 07:51 AM, the housekeeper observed Resident #8 hitting his room mate (Resident #5) on the back. The room mate was on the bed of Resident #8 and would not get off. The progress notes also indicates that Resident #8 was asked why he/she hit Resident #5 and Resident #8 indicated "I hit him because I wanted my bed."</p> <p>Per review of the progress notes on 1/23/13 there was no evidence within the Social Service progress notes indicating that Social Services had assessed Resident #8 and #5 regarding the incident of resident to resident altercation where Resident #8 was the aggressor and Resident #5 was the victim of abuse.</p> <p>Per interview on 1/23/13, the facility Social Work worker (SSW) confirmed that if there was no documentation in the clinical record by SS that this meant that no assessment had been done by Social Services regarding the resident to resident altercation and potential abuse. The SSW</p>	F 250		

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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 250	Continued From page 46 confirmed on 1/23/13 that if there was no documentation from SS that this meant the the SSW did not evaluate residents current care plan of those residents involved in resident to resident altercations resulting in abuse. The SSW also confirmed on 1/23/13 that no documentation also meant that the SSW did not ensure that the current care plan was sufficiently meeting the specific needs of residents involved in resident to resident altercations where there is a documented aggressor and documented victim. The Interim Administrator on 1/30/13 confirmed that the care plans for Resident #8 and Resident #5 were not reviewed and revlved until 1/25/13, 12 days after the incident occurred on 1/13/13 to ensure the care plan met the potential and actual needs of Resident #8 and Resident #5 involved in resident to resident altercation and interventions placed to ensure that resident to resident altercation and abuse did not occur again. Per interview with the Interim Director of Nursing (IDNS), and Corporate Clinical Evaluator on 1/23/13, The IDNS confirmed that he/she felt these incidences of resident to resident altercations were abuse and the facility expectation is that the SSW would address the needs of residents involved in resident to resident altercations. 5. Per review of the facility's internal investigation and clinical record on 1/29/13, they indicated that on 1/14/13, Resident #7 slapped Resident #6 on the left side of the face for no reason. Per the progress note it indicates staff asked Resident #7 if she/he slapped Resident #6 and the resident confirmed he/she did hit Resident #6.	F 250		

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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)	(X6) COMPLETION DATE
F 250	Continued From page 47 Per review of the progress notes on 1/23/13 there was no evidence within the Social Service progress notes indicating that Social Services had assessed Resident #7 and #6 regarding the incident of resident to resident altercation where Resident #7 was the aggressor and Resident #6 was the victim of abuse. Per interview on 1/23/13, the facility Social Work worker (SSW) confirmed that if there was no documentation in the clinical record by SS that this meant that no assessment had been done by Social Services regarding the resident to resident altercation and potential abuse. The SSW confirmed on 1/23/13 that if there was no documentation from SS that this meant the the SSW did not evaluate residents current care plan of those residents involved in resident to resident altercations resulting in abuse. The SSW also confirmed on 1/23/13 that no documentation also meant that the SSW did not ensure that the current care plan was sufficiently meeting the specific needs of residents involved in resident to resident altercations where there is a documented aggressor and documented victim. The Interim Administrator on 1/30/13 confirmed that the care plans for Resident #7 and Resident #6 were not reviewed and revised until 1/25/13, 11 days after the incident occurred on 1/14/13 to ensure the care plan met the potential and actual needs of Resident #7 and Resident #6 involved in resident to resident altercation and interventions placed to ensure that resident to resident altercation and abuse did not occur again. Per interview with the Interim Director of Nursing (IDNS), and Corporate Clinical Evaluator on	F 250		

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NAME OF PROVIDER OR SUPPLIER DOWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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(4) 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 250	Continued From page 48 1/23/13, The IDNS confirmed that he/she felt these incidences of resident to resident altercations were abuse and the facility expectation is that the SSW would address the needs of residents involved in resident to resident altercations.	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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that the comprehensive care plans for 8 of 10 identified residents (Resident #1, #2, #3, #4, #5, #6, #7, #8), who were involved in resident to resident altercations	F 280	<u>F280 483.20(D)(3),</u> <u>483.10(K)(2) RIGHT TO</u> <u>PARTICIPATE PLANNING CARE</u> <u>-REVISE CP</u> Corrective action accomplished for those residents found to have been affected; Residents #1 and # 2 no longer reside at the facility. Residents #3, #4, #5, #6, #7, and #8 have been re-assessed by the IDT and their care plans and/or behavior management plans have been revised. How the facility will identify other residents having the potential to be affected and what corrective action has been taken; IDT will identify each resident who has behaviors through walking rounds.	

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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 280	Continued From page 49 resulting in abuse were not reviewed and revised after the resident to resident incidences to ensure that the care plans reflected the current specific needs of each resident. 1. Per review of the clinical record on 1/23/13, Resident #1 was admitted to the facility on 7/5/11 with diagnoses that include; early onset Alzheimer's, memory loss, and depressive disorder. Per review of the progress notes, on 1/23/13, Resident #1 was in the dining room during lunch on 9/22/12 and took a roll from Resident #2. When Resident #2 said something to Resident #1, he/she started hitting/slapping Resident #2 on the head several times. Per review of the clinical record on 1/23/13, the progress notes dated on 9/27/12 at 3:56 AM indicated, Resident #1 was in the main dining room and struck Resident #2 forcefully in the ear with a spoon. The assessment indicates Resident #2's right ear pinkish red and Resident #2 complained it "hurt". Per review of the clinical record on 1/23/13, the progress notes dated on 10/11/12 at 1:19 AM, state that Resident #1 was observed by another resident's family member, slapping and pushing Resident #4 to the floor causing Resident #4 injuries. Per review of the progress notes there was no evidence within the Social Service progress notes indicating that Social Services had assessed Resident #1, #2 or #4 regarding the incident of resident to resident altercations where Resident	F 280	Residents who have behaviors and personal histories that render them at risk for abusing other residents or being abused by other residents will be reviewed by the IDT, plan of care reviewed, physician and psychologist consulted, and a behavior management plan developed. Measures or systemic changes put into place to ensure that the deficient practice will not recur; A Behavior Management Team will be established, including membership minimally by nursing, social service, activities, rehabilitation, and psychologist. This team will meet weekly and conduct behavior management rounds. The resident's attending physician will be notified of behavior round team assessments.	

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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 280	Continued From page 50 #1 was the aggressor and Resident #2 and #4 were the victims of abuse on 9/22/12, 9/27/12 and 10/11/12. Per interview on 1/23/13, the facility Social Service worker (SSW) confirmed that no assessment had been done by Social Services regarding resident to resident abuse on 9/22/12, 9/27 and 10/11/12. The SSW confirmed that he/she did not evaluate Residents #1, #2, and #4 to ensure that the current care plan was sufficiently meeting the specific needs of Resident #1 being the aggressor and Residents #2 and #4 being the victims of abuse. The SSW confirmed that the care plans for Residents #1, #2 and #4 had not been reviewed and revised to meet the potential and actual needs of a resident involved in resident to resident altercation resulting in abuse and interventions placed to ensure that resident to resident abuse did not occur again. Per interview with the Interim Director of Nursing (IDNS), and Corporate Clinical Evaluator on 1/23/13, The IDNS confirmed that he/she felt these incidences of resident to resident altercations were abuse and the facility expectation is that the SSW would address the needs of residents involved in resident to resident altercations. 2. Per review of the clinical record on 1/23/13, it indicates that Resident #2 was re-admitted to the facility on 10/2/12, with diagnoses that include persistent mental disorder and psychosis. Per review of the clinical record on 1/23/13, the progress note dated 10/26/12 at 4:38 PM, indicates "Resident very confused, high agitation,	F 280	Cue cards for each resident at risk for altercations have been developed to assist staff with a tool to consult for resident behaviors, triggers, and intervention strategies. IDT members will be provided with education on developing behavior management strategies and care plans aimed at preventing occurrences of resident to resident altercations/abuse. How the corrective actions will be monitored to ensure that the deficient practice does not recur/quality assurance program; Residents who are displaying exacerbated behaviors will be identified during Concurrent Review. The resident will be reviewed by the IDT, a medical record review conducted, plan of care revised as warranted, and interventions implemented.	

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NAME OF PROVIDER OR SUPPLIER HOWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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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
280	Continued From page 51 screaming at staff and residents, combative, hitting, grabbing, punching, kicking, grabbed the sweatshirt of another resident and almost made the other resident fall". The documentation did not indicate who the other resident was. Per review of the progress notes on 1/23/13 there was no evidence within the Social Service progress notes indicating that Social Services had assessed Resident #2 regarding the incident of resident to resident altercation where Resident #2 was the aggressor and a unidentified resident was the potential victim on 10/26/12. Per interview on 1/23/13, the facility Social Service worker (SSW), he/she confirmed that no assessment had been done by Social Services regarding the resident to resident altercation and potential abuse on 10/26/12. The SSW confirmed that he/she did not evaluate Resident #2 to ensure that the current care plan was sufficiently meeting the specific needs of Resident #2 being the aggressor. The SSW was not able to identify who the potential victim was in the altercation documented in the medical record on 10/26/12. The SSW confirmed that the care plans for Resident #2 had not been reviewed and revised to meet the potential and actual needs of a resident involved in resident to resident altercation and interventions placed to ensure that resident to resident altercation did not occur again. Per interview with the Interim Director of Nursing (IDNS), and Corporate Clinical Evaluator on 1/23/13, the IDNS confirmed that he/she felt these incidences of resident to resident altercations were abuse and the facility	F 280	The Director of Social Services, Director of Nursing, or Regional Director/Quality Improvement Nurse will audit care plans at least weekly to ensure that comprehensive care plans are in place and revised to prevent occurrences of resident to resident altercations/abuse, and monitor changes that may trigger abusive behavior. Results of the audits will be reviewed and submitted to the facilities QAPI meeting for trending and tracking with remedial measures initiated as identified. Person Responsible; Social Services Director Date of Correction; March 1, 2013 <i>F280 POC accepted 2/20/13 McWhan RNJ PINE</i>	

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(4) 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 280	Continued From page 52 expectation is that the SSW would address the needs of residents involved in resident to resident altercations. The IDNS and Corporate Clinical Evaluator were unable to identify the other resident involved in the documented altercation with Resident #2 on 10/26/12. 3. Per review of the clinical record on 1/23/13, the clinical record indicates that Resident # 3 was re-admitted to the facility on 10/9/11 with diagnoses that included, vascular dementia and depressive disorder. Per review of the clinical record on 1/23/13, the progress notes dated 12/10/12 at 7:52 PM, indicate that Resident #3 was sitting in the hallway in his/her chair continually yelling out. Another resident came up to Resident #3 and slapped him/her to the side of the head and said, shut up you woke me up. Per review of the progress notes on 1/23/13 there was no evidence within the Social Service progress notes indicating that Social Services had assessed Resident #3 regarding the incident of resident to resident altercation where Resident #3 was the victim of abuse by an unidentified resident on 12/10/12. Per interview on 1/23/13, the facility Social Service worker (SSW) confirmed that no assessment had been done by Social Services regarding the resident to resident altercation and abuse on 12/10/12. The SSW confirmed that he/she did not evaluate Resident #3 to ensure that the current care plan was sufficiently meeting the specific needs of Resident #3 who was the victim of abuse on 12/10/12 by another resident. The SSW was not able to identify who the potential aggressor in the altercation documented	F 280		

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NAME OF PROVIDER OR SUPPLIER DWAN COURT HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641		
(4) 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
280	<p>Continued From page 53</p> <p>in the medical record on 12/10/12. The SSW confirmed that the care plans for Resident #3 had not been reviewed and revised to meet the potential and actual needs of a resident involved in resident to resident altercation and the victim of abuse and interventions placed to ensure that resident to resident altercation and abuse did not occur again.</p> <p>Per interview with the Interim Director of Nursing (IDNS), and Corporate Clinical Evaluator on 1/23/13, The IDNS confirmed that he/she felt the incident on 12/10/12 where there was a resident to resident altercation and was considered abuse. The IDNS confirmed that the facility expectation is that the SSW would address the needs of residents involved in resident to resident altercations. The IDNS and Corporate Clinical Evaluator were unable to identify the other resident involved in the documented altercation with Resident #2 on 12/10/12.</p> <p>4. Per review of the facility's internal investigation and clinical record on 1/29/13, they indicated that on 10/26/12 Resident #8 was admitted to the facility with diagnoses that included unspecified anxiety states, dementia without behavioral disturbances and depressive disorder. The clinical record indicated that on 1/13/13 at 07:51 AM, the housekeeper observed Resident #8 hitting his room mate (Resident #5) on the back. The room mate was on the bed of Resident #8 and would not get off. The progress notes also indicates that Resident #8 was asked why he/she hit Resident #5 and Resident #8 indicated "I hit him because I wanted my bed."</p>	F 280			

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NAME OF PROVIDER OR SUPPLIER DOWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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DEFICIENCY 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
280	<p>Continued From page 54</p> <p>Per review of the progress notes on 1/23/13 there was no evidence within the Social Service progress notes indicating that Social Services had assessed Resident #8 and #5 regarding the incident of resident to resident altercation where Resident #8 was the aggressor and Resident #5 was the victim of abuse.</p> <p>Per interview on 1/23/13, the facility Social Work worker (SSW) confirmed that if there was no documentation in the clinical record by SS that this meant that no assessment had been done by Social Services regarding the resident to resident altercation and potential abuse. The SSW confirmed on 1/23/13 that if there was no documentation from SS that this meant the the SSW did not evaluate residents current care plan of those residents involved in resident to resident altercations resulting in abuse. The SSW also confirmed on 1/23/13 that no documentation also meant that the SSW did not ensure that the current care plan was sufficiently meeting the specific needs of residents involved in resident to resident altercations where there is a documented aggressor and documented victim. The Interim Administrator on 1/30/13 confirmed that the care plans for Resident #8 and Resident #5 were not reviewed and revised until 1/25/13, 12 days after the incident occurred on 1/13/13 to ensure the care plan met the potential and actual needs of Resident #8 and Resident #5 involved in resident to resident altercation and interventions placed to ensure that resident to resident altercation and abuse did not occur again.</p> <p>Per interview with the Interim Director of Nursing (IDNS), and Corporate Clinical Evaluator on 1/23/13, The IDNS confirmed that he/she felt</p>	F 280		

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NAME OF PROVIDER OR SUPPLIER DOWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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280	Continued From page 55 these incidences of resident to resident altercations were abuse and the facility expectation is that the SSW would address the needs of residents involved in resident to resident altercations. 5. Per review of the facility's internal investigation and clinical record on 1/29/13, they indicated that on 1/14/13, Resident #7 slapped Resident #6 on the left side of the face for no reason. Per the progress note it indicates staff asked Resident #7 if she/he slapped Resident #6 and the resident confirmed he/she did hit Resident #6. Per review of the progress notes on 1/23/13 there was no evidence within the Social Service progress notes indicating that Social Services had assessed Resident #7 and #6 regarding the incident of resident to resident altercation where Resident #7 was the aggressor and Resident #6 was the victim of abuse. Per interview on 1/23/13, the facility Social Work worker (SSW) confirmed that if there was no documentation in the clinical record by SS that this meant that no assessment had been done by Social Services regarding the resident to resident altercation and potential abuse. The SSW confirmed on 1/23/13 that if there was no documentation from SS that this meant the the SSW did not evaluate residents current care plan of those residents involved in resident to resident altercations resulting in abuse. The SSW also confirmed on 1/23/13 that no documentation also meant that the SSW did not ensure that the current care plan was sufficiently meeting the specific needs of residents involved in resident to	F 280		

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NAME OF PROVIDER OR SUPPLIER DOWAN COURT HEALTH & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641	

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F 280	Continued From page 56 resident altercations where there is a documented aggressor and documented victim. The Interim Administrator on 1/30/13 confirmed that the care plans for Resident #7 and Resident #6 were not reviewed and revised until 1/25/13, 11 days after the incident occurred on 1/14/13 to ensure the care plan met the potential and actual needs of Resident #7 and Resident #6 involved in resident to resident altercation and interventions placed to ensure that resident to resident altercation and abuse did not occur again. Per interview with the Interim Director of Nursing (IDNS), and Corporate Clinical Evaluator on 1/23/13; The IDNS confirmed that he/she felt these incidences of resident to resident altercations were abuse and the facility expectation is that the SSW would address the needs of residents involved in resident to resident altercations.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide services that meet professional standards of quality for 1 of 10 applicable resident regarding medication management. (Resident#1,#2,#3,#4,#5,#6,#7,#8,and #9) Findings include: 1. Per record review on 01/29/13 of Resident	F 281	<u>281 483.20(k)(s)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</u> Corrective action accomplished for those residents found to have been affected; For resident #9, medications are being administered according to professional standards.	

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NAME OF PROVIDER OR SUPPLIER DOWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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F 281	Continued From page 57 #9's medical record, wrong medication was given that was not in accordance with physician orders and there was a failure to document and administer medication based on nursing professional standards of practice. Per review of the Medication Administration Record (MAR) there was a physician's order for Morphine Sulfate Extended Release 15 mg (milligrams) to be given BID (twice per day at 9:00 AM and HS (hour of sleep). Per the MAR, Morphine was given 01/03/13 at 12 Noon. The Narcotic Book shows the medication as being given at 9:50 AM that day. Per interview on 01/29/13 at 4:00 P.M. the nurse stated "I didn't give [all] the morning meds, as I knew the resident was not taking anything that morning and I gave it at noon." When asked why the Narcotic Book has it listed as being given at 9:50 AM, the nurse stated "I can't remember if I poured it at 9:50 AM, and then held it in the med drawer." S/he confirmed that this is not best practice for pouring, storing, documentation or administering narcotic medication. In addition, Resident #9 had a physician's order for Clonazepam (an anti-anxiety medication) to be given at HS only. Per the MAR, Resident #9 received Clonazepam 1.5 mg on the morning of 01/16/13 at 10:00 AM and 01/17/13 at 7:00 AM, although the physician order is for an evening (HS) dose only. Per review of an incident report dated 01/17/13, it states "when doing count in afternoon with on coming nurse noticed count was off. Found that I had given patient a clonazepam instead of a.m. MS contin [Morphine] 15 mg". Per interview at 4:48 P.M. on 01/29/13 the DNS stated that there should be a	F 281	How the facility will identify other residents having the potential to be affected and what corrective action has been taken; Residents who have orders for medications have the potential to be affected. Medication pass and Narcotic Count observation audits will be conducted by the pharmacy consultant. Areas identified as needing correction will be addressed and corrected by the Director of Nursing. Measures or systemic changes put into place to ensure that the deficient practice will not recur; Licensed nursing staff will be re-educated on administering medications and conducting narcotic shift count according to professional standards. Licensed nurses will be required to audit their MAR and Narcotic Count Book each	
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NAME OF PROVIDER OR SUPPLIER DUNN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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F 281	Continued From page 58 note or incident report on the 1/16/13 error and the incident report process (for wrong medication), which would investigate and follow-up, is not noted for the 1/17/13 error. Per interview on 01/29/13 at 4:48 P.M. the IDNS (Interim Director of Nursing Services) confirmed that nurses did not follow professional standards of quality by giving wrong medications and documenting and/or pouring medication incorrectly. Reference: Lippincott Nursing Manual, Williams & Wilkins, 8th edition	F 281	shift to ensure that documentation is present. How the corrective actions will be monitored to ensure that the deficient practice does not recur/quality assurance program; Registered Nursing staff will conduct medication administration and shift narcotic count observation audits; and medication administration records/narcotic count books to ensure that medications are being managed according to professional standards. This will be done at least three times per week.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide for or arrange services by qualified persons in accordance with each resident's written plan of care for 1 of 10 residents (Resident #9) identified. The findings include: 1. Per review on 01/29/13 of the medical record,	F 282	The Regional Director/Quality Improvement Nurse will conduct audits of medication error incidents. Results of the audits will be reviewed and submitted to the facilities QAPI meeting for trending and tracking with remedial measures initiated as identified.	

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NAME OF PROVIDER OR SUPPLIER KOWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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F 282	Continued From page 59 Resident #9 was admitted to the facility in March 2011 with diagnoses that include Dementia, muscle weakness, anxiety and the resident had a recent hip fracture in November 2012. Per the plan of care dated 12/06/12 for "At risk for injury related to behaviors, i.e.; calls out frequently, many times [resident] is found on floor on mat beside bed, multiple attempts to stand unassisted..." One of the several interventions included "low bed in place and tab alarms." Per a nursing progress note dated 01/02/12 at 9:33 P.M. states "about 2050 (8:50 PM) found on floor near the bathroom door...called and updated [family] and asked about 15 minute checks, which we were doing and asked if we had low bed with a mat on the floor. I told [family] that I would ask them about this. Called DON [DNS] who was here as evening supervisor and [s/he] is going to make sure it is done tomorrow". The resident was without, as care planned, a low bed and mat until the next day. Per interview at 5:11 P.M. on 01/20/13 the DNS stated "we sometimes take beds when a resident is not using them and this resident returned to the facility on 01/02/13 in the early afternoon". S/he further noted that the resident would've still been appropriate for a low bed and mat as the mobility status did not change and the resident was still at high risk of falls. S/he confirmed that the services were not provided according to the written care plan.	F 282	Person Responsible; The Director of Nursing Date of Correction; March 1, 2013 <i>F282 POC accepted 2/26/13 mcluhan/pmc</i> 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Corrective action accomplished for those residents found to have been affected; Resident #9s has been reviewed by the IDT and his/her care plan is reflective of current needs and interventions. How the facility will identify other residents having the potential to be affected and what corrective action has been taken;	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	IDT will identify each resident who has behaviors through walking rounds.	

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NAME OF PROVIDER OR SUPPLIER ROWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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F 323	<p>Continued From page 60 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that the environment was free of accident hazards and that each resident received adequate supervision and assistance devices to prevent accidents for 2 applicable residents. (Resident #9 &10) Findings include:</p> <p>1. Per record review on 01/28/13 Resident #9, did not have an environment as free of an accident hazard as possible. The resident's diagnoses include dementia with agitation, a history of multiple falls, a fracture sustained to the left hip in November 2012 and hemiplegia (left side weakness).</p> <p>Per a fax to the physician dated 01/25/13 at 0800 states "at change of shift 0700 patient found, body on floor with [resident's] neck caught in rail, [resident's] upper body was lifted to get the neck from the rail, neck very red, patient moving head." A nurse progress note dated 01/25/13 at 2:05 PM stated "I had been in to see patient about 0645-0650. [s/he] was asking to get out of bed and told [resident] that LNA's would be in shortly, at that time [resident] was lying facing wall with bell in place and tab alarms attached. At 0700 LNA's yelling for help went to room found patient lying on the floor with [her/his] neck chin caught in</p>	F 323	<p>Residents who are at risk for injury related to behaviors have the potential to be affected. IDT will review and revise each resident's care plan to reflect current needs and interventions.</p> <p>Measures or systemic changes put into place to ensure that the deficient practice will not recur;</p> <p>Staff will be educated on implementing revised care plan interventions timely.</p> <p>How the corrective actions will be monitored to ensure that the deficient practice does not recur/quality assurance program; Residents who are newly admitted or re-admitted to the facility and residents with new or changes in their care plan interventions will be identified during concurrent review and audited to ensure that the intervention has been implemented.</p>	

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F 323	<p>Continued From page 61</p> <p>the bed rail, [s/he] was not yelling out, asked male nurse to come help me, he lifted [resident] by the shoulders and lay [resident] on the floor, the patient started complaining that the floor was cold and moving [his/her] neck, without difficulty. vital signs and neuro checks done within normal limits. Patient's neck red but no complaining of pain and moving it. got resident up into wheelchair...started 15 minute checks and got order to discontinue the side rails...Doctor faxed and sent back response to check swallowing, breathing and speech, which had already been checked and monitored....most of redness on neck faded, [s/he] has a 6.5 cm long red mark on [his/her] neck."</p> <p>Per review of the care plan dated 12/21/12 for impaired physical mobility related to left hip fracture with repair, history of CVA (stroke) and neuropathy in bilateral feet, the care plan notes the interventions as maximum assist of 2 staff for bed mobility, encourage/assist with repositioning as needed and continue to monitor and re-educate regarding the need for 2 maximum assist with transfer. Per observation on 01/29/13 Resident #9's bed was a low-type bed that had a scoop mattress, the right side of the bed was against the wall and there was a small mattress was on the floor next to the open (left) side of the bed.</p> <p>The significant change assessment dated 12/02/12, after the resident sustained a fracture of the left hip in November 2012, Section O (side rail evaluation) notes that the resident has difficulty with balance or poor trunk control and has demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed.</p>	F 323	<p>The Director of Nursing or Nurse Manager/Supervisor will assign nursing staff to conduct random direct observation audits to ensure that care plan interventions are followed.</p> <p>The results of the audits will be reviewed and submitted to the facilities QAPI meeting for trending and tracking with remedial measures initiated as identified.</p> <p>Person Responsible;</p> <p>The Director of Nursing</p> <p>Date of Correction;</p> <p>March 1, 2013 <i>F2B2 PDC accepted 2/28/13 m callhounRN/PMC</i></p> <p><u>323 483.25(h) FREE OF</u> <u>ACCIDENT</u> <u>HAZARDS/SUPERVISION/DEVI</u> <u>CES</u></p> <p>Corrective action accomplished for those residents found to have been affected;</p>	

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F 323	<p>Continued From page 62</p> <p>Half rails bilaterally were indicated and 'serve as an enabler to promote independence' and an MD order was in place. Per review of the 01/03/13 (re-admission from a hospital stay) notes, the resident arrived via stretcher with assist of two. In addition, in Section D, 'total assist' is needed for personal hygiene, mobility, transfer, and toilet use. Section E (fall risk) lists level of consciousness/mental status as 'intermittent confusion' and under section H (neurological) as 'lethargic'. Section O (side rail evaluation) notes that the resident has difficulty w/ balance or poor trunk control and has demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed. Again, half rails bilaterally were indicated and 'serve as an enabler to promote independence' and an MD was order was in place.</p> <p>Per review of the signed physician's orders dated January 2013 there is no order for the side rails. Furthermore, there is no determination if the side rail use was appropriate given the resident's current history of falls, transfer ability and risk factors such as entrapment. There was also no assessment for the use of a scoop mattress.</p> <p>Per interview with physical therapy (PT) staff on 01/29/12 at 11:00 AM, s/he stated that the resident had plateaued with therapy as the resident is unable/unwilling to work on gaining mobility independence. The PT was unable to answer as to why the bed rails were removed on the day of the incident and to why a scoop mattress was put in place if the resident was assessed as using side rails as enablers for bed mobility. Per interview on 01/29/13 at 3:00 p.m. LNA (Licensed Nursing Assistant) staff stated "[Resident #9's]</p>	F 323	<p>On January 30, 2013 Resident #10's bed was immediately switched with a bed and mattress without gaps, she was assessed for the need for side rails and subsequently, the side rails were removed and an assist bar was installed on the left side of her bed.</p> <p>How the facility will identify other residents having the potential to be affected and what corrective action has been taken;</p> <p>On January 28, 29, and 30, 2013 every bed in the facility was evaluated for potential entrapment areas, e.g., gaps between side rail and mattress, ill-fitting mattress, gaps between head or foot board and mattress, etc. Beds have been evaluated for gaps and findings were corrected, with spacers, replacement of mattresses, etc. Residents with side rails on their bed were assessed by a licensed nurse with input from the IDT.</p>	

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F 323	<p>Continued From page 63</p> <p>bottom was on the floor and [her/his] neck was pressed against the bar and because of [her/his] weight [s/he] was unable to move or get up, [s/he] is 50-50 when it comes to moving on [her/his] own but lately we need to do most things for [the resident]". S/he indicated that the resident frequently tries to "wiggle off the bed down past the side rail".</p> <p>Per review of the facility's policy for assessing side rails, it notes that the use of side rails requires a complete assessment of the resident's mobility and cognitive functioning to determine the category of use. It further states that side rails used as an enabler for mobility must include the following criteria: a) an evaluation of the ability to move about in bed; b) an evaluation of whether the resident is able to use the side rails(s) in turning; c) a determination that the resident's ability to transfer using the side rail outweighs the risk of falls associated with the use of the side rails. Also, the side rail assessment must include a determination that there is no endangerment or entrapment risk from the gap between side rail and mattress or increased risk of injury from extremities caught in side rails, and states that side rail pads and bolsters are to be used when indicated ensure safety with use of side rails.</p> <p>Per review of the side rail assessment dated 01/03/13 after a hospital admission, notes that the resident has difficulty with balance or poor trunk control and has demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed. Furthermore, there is no determination if the side rail use was appropriate given the resident's current history of falls, transfer ability and risk factors such as</p>	F 323	<p>Measures or systemic changes put into place to ensure that the deficient practice will not recur;</p> <p>Side rails are no longer utilized at the center.</p> <p>Staff will be educated on "risk of entrapment" and checking beds and mattresses for gaps, loose parts, etc. and what to do should they find such.</p> <p>How the corrective actions will be monitored to ensure that the deficient practice does not recur/quality assurance program;</p> <p>Direct observation audits will be conducted for each bed to monitor that there are no potential entrapment areas and areas identified corrected immediately.</p> <p>Results of the audits reviewed and submitted to the facilities QAPI meeting for trending and tracking with remedial measures initiated as identified.</p>	

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F 323	<p>Continued From page 64 entrapment.</p> <p>Per review of the incident report there is no indication as to the mental status or predisposing environmental factors. It erroneously states 'no injuries observed' and the predisposing physiological factors only as history of recent falls, but fails to note co-morbidities, functional impairment or use of assistance devices.</p> <p>Per interview on 01/30/13 at 10:57 AM, the DNS confirmed the assessment was not clear to determine if side rails (assistance device) were being used appropriately or if the resident's ability to use side rails outweigh the risk as an accident hazard and that the resident sustained injuries in multiple attempts to exit the bed around the bottom of the side rail during the months of December 2012 and January 2013.</p> <p>Per interview on 01/29/13 at 1:00 PM, the Administrator stated that the resident was on the floor and the head/neck area was up against the rail. The Administrator confirmed that the resident needed to be assisted off the floor and that the side rails were removed and a scoop mattress was ordered because of the safety issue.</p> <p>2. Per observation on 01/28/13 at 3:00 PM, the nurse surveyor observed Resident #10's mattress as having a greater than 5 inch gap between the left side rail and the mattress. The right side of the bed was up against the wall. Per further observation on 01/29/13 at 9:00 AM, there remained a gap of about 3 inches between the left side rail and the mattress, while the bottom of the mattress did not reach the foot of</p>	F 323	<p>Person Responsible;</p> <p>Executive Director</p> <p>Date of Correction;</p> <p>January 30, 2013.</p> <p><i>F323 POC accepted 2/12/13 McWhorter/PMC</i></p>	

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F 323	Continued From page 65 the bed, but had a mattress bolster to fill the space. Per interview on 01/29/13 at 12:13 PM, the Clinical Director stated that the side rails are used as enablers and also both rails are raised to "keep the mattress in place". Per observation on 01/30/13 at 11:36 AM, the foot of the bed mattress bolster was not secured and a side gap in the mattress remained at 3 inches. In addition, the call light was not near the resident and the resident stated at that time "I can't reach the bell and sometimes I can't find it". The resident did demonstrate the ability to use the side rail to get on the side of the bed, however the resident's leg got stuck under the rail. Per observation and confirmed by the VP of Clinical Services on 01/30/13 at 11:45 AM, the mattress bolster at the foot of the bed was not secured [as indicated], and a gap between the rail and the mattress remained. At this time a new bed/mattress was obtained to assure resident safety.	F 323		
F 356 SS=C	Also see F221 483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356	356 483.30(e) POSTED NURSE STAFFING INFORMATION Corrective action accomplished for those residents found to have been affected; The daily census and staffing information is being posted as required.	

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F 356	Continued From page 66 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that daily census and staffing information was posted as required. This potentially affects all Residents in the facility. Findings include: During observation of the facility on 01/30/13 at 3:15 PM, the facility's census and daily staffing information was not in a clear and readable format. The posting showed the RN (Registered Nurse) staffing for the day shift as 2-3 and the LPN (Licensed Practical Nurse) staffing on the day shift as 9-10. Per interview at that time the DNS (Director of Nursing Services) stated "I think it means that staffing changes during the shift but I am not sure". Per further review of the daily census, on 01/21/13 the day shift shows RN staffing as 3-4 and the LPN as 3-2, on 01/15/13	F 356	How the facility will identify other residents having the potential to be affected and what corrective action has been taken; Residents who reside at the center have the potential to be affected. Measures or systemic changes put into place to ensure that the deficient practice will not recur; Nursing Supervisor will update the staffing information with any changes in the staffing pattern each shift. How the corrective actions will be monitored to ensure that the deficient practice does not recur/quality assurance program; The Director of Nursing or designee will audit the staffing information to ensure that it is correct. This will be done at least-weekly.	
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F 356	Continued From page 67 LPN on the day shift as 3-2 and on 01/13, 01/12 and 01/11 for the day shift LPN staffing as 4-3. RN staffing on the evening shift on 01/05 & 01/06/13 states 3-2. Per interview at 3:36 PM, the scheduler stated that "at some point during the shift there is a change in the staffing pattern and probably we should show the actual hours when there is a change". S/he confirmed that the information, as posted, is not in a clear and readable format.	F 356	Results of the audits will be reviewed and submitted to the facilities QAPI meeting for trending and tracking with remedial measures initiated as identified. Person Responsible;	
F9999	FINAL OBSERVATIONS Per Vermont Licensing and Operating Rules for Nursing Homes: Regulation 7.13(d)(1)(i): (d) Staffing Levels. The facility shall maintain staffing levels adequate to met resident needs. (1) At a minimum, nursing facilities must provide: (i) no fewer than 3 hours of direct care per resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and of the three hours of direct care, no fewer than 2 hours per resident per day must be assigned to provide standard LNA care (such as personal care, assistance with ambulation, feeding, etc.) performed by LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to assure that no fewer than 2 hours	F9999	Director of Nursing Date of Correction; March 1, 2013 <i>F356 POC accepted 2/28/13 McCluhan RN, PML</i> State Regulation 7.13(d)(1)(i): Staffing Levels Corrective action accomplished for those residents found to have been affected; The facility is running at minimum at 2.0 PPD LNA staffing daily. How the facility will identify other residents having the potential to be affected and	

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F9999	<p>Continued From page 68</p> <p>per resident per day are assigned to provide standard LNA (Licensed Nursing Assistant) care. Findings include:</p> <p>Per record review, the facility provided less than two (2) hours per resident per day of assigned LNA staffing on the following days:</p> <p>November 2012 - 1, 25, 26 December 2012 - 2, 3, 4, 15, 16, 18, 22, 23 January 2013 - 6, 10, 12, 13, 19, 20, 24, 26, 27, 28</p> <p>Per interview on 01/30/13 at 2:48 p.m., the Scheduler confirmed that the State required 2 hours of Direct care hours per resident per day were not met on the above days and stated that although the facility was aware, "we were just short".</p> <p>.....</p> <p>Regulation 3.14 (l): Emergency Transfer or Discharge of Residents. An emergency discharge or transfer may be made with less than thirty (30) days' notice under the following circumstances:</p> <p>(1) The resident's attending physician documents in the resident's record that the discharge or transfer is an emergency measure necessary for the health and safety of the resident or other residents; or (2) A natural disaster or emergency necessitates the evacuation of residents from the home; or (3) The resident presents an immediate</p>	F9999	<p>what corrective action has been taken;</p> <p>Residents who reside at the center have the potential to be affected.</p> <p>Measures or systemic changes put into place to ensure that the deficient practice will not recur;</p> <p>Minimum number of LNA required per day to meet a 2.0 PPD has been developed, communicated to the Nursing Supervisors, and LNA staffing numbers will be managed on a daily basis to ensure that the facility is staffed at no lower than a 2.0 PPD for LNA staff.</p> <p>The Director of Nursing will conduct audits to ensure that this process is effective at meeting the LNA daily staffing PPD of at least 2.0.</p> <p>Results of the audits will be reviewed and submitted to the facilities QAPI meeting for trending and tracking with</p>	

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F9999	<p>Continued From page 70</p> <p>severe agitation, combativeness, disrobing and refusal to be controlled". Per review of the physician's orders, a verbal order was obtained from physician at 6:00 PM to "transport to CVMC ER".</p> <p>Per review of the clinical record, it indicated that there was no evidence in the physicians progress notes indicating the emergent need for Resident #1 to be discharged on 8/5/12 to the emergency room because Resident #1's health and safety and the health and safety of the other residents in the facility was at risk. There was also no evidence in the clinical record that the State regulatory agency was notified of the need to utilize and emergent discharge for the health and safety of Resident #1 and the health and safety of the other residents in the facility.</p> <p>Per review of the clinical record by the Interim Director of Nursing (IDNS) on 1/30/13, he/she confirmed that there was no documentation by the facility physician in the clinical record of Resident #1 regarding the need to utilize an emergent discharge to secure the health and safety of Resident #1 and the health and safety of the other residents in the facility. Per interview the IDNS confirmed that the State regulatory agent was not notified of the need to utilize an emergent discharge for Resident #1 on 8/5/12. Per review of the clinical record on 1/30/13, the IDNS confirmed that there was no specific documentation per the regulatory requirements from the physician indicating the specific behaviors of Resident #1 and how his/her health and safety was at risk along with the health and safety of the other residents that required the need for an emergent discharge. The DNS also</p>	F9999	<p>resident and/or legal representative will be provided with a written notice of the bed hold policy.</p> <p>Measures or systemic changes put into place to ensure that the deficient practice will not recur;</p> <p>Licensed nursing staff will be provided with education on providing the resident with a written notice of the emergency transfer/bed hold policy and sending a copy of such with the transfer information.</p> <p>The Admission Assistant and Admission Director will be provided with education on providing a written bed hold notice to the family and/or legal representative within 24 hour of the transfer, or next day that the post office is open. If mailed, it will be done utilizing return receipt.</p>	

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F9999 Continued From page 71
confirmed that there was no documentation by the physician of what interventions were utilized prior to the resident's discharge.

2. Per review of the medical record on 1/23/13, it was documented by the Licensed Practical Nurse (LPN) Resident #1 on 9/27/12 at 3:56 AM was in the main dining room and struck another resident forcefully in the ear with a spoon and Resident #1 was throwing silverware through the dining room. The nurse documented "As resident passed near this writer, [he/she] continuously struck/attempted to strike me...[The IDNS] was consulted and instructed writer to contact resident's doctor/to transport to CVH ED. Order was received and resident transported to CVH ED." Per review of the verbal order written on 9/26/12 at 5:00 PM, the physicians verbal order indicates; "May send to CVH for combative behaviors."

Per review of the clinical record, it indicated that there was no evidence in the physician's progress notes indicating the emergent need for Resident #1 to be discharged on 9/26/12 to the emergency room because Resident #1's health and safety and the health and safety of the other residents in the facility was at risk. There was also no evidence in the clinical record that the State regulatory agent was notified of the need to utilize and emergent discharge for the health and safety of Resident #1 and the health and safety of the other residents in the facility

Per review of the clinical record by the Interim Director of Nursing (IDNS) on 1/30/13, he/she confirmed that there was no documentation by the facility physician in the clinical record of Resident #1 regarding the need to utilize an

F9999

How the corrective actions will be monitored to ensure that the deficient practice does not recur/quality assurance program;

The Executive Director will audit residents who are emergently transferred to ensure that the bed hold notice was provided to the patient and family or legal representative per regulation.

Results of audits reviewed and submitted to the facilities QAPI meeting for trending and tracking with remedial measures initiated as identified.

Person Responsible;

The Executive Director

Date of compliance;

March 1, 2013

*F9999 POC accepted 2/26/13
mculinonren/pmc*

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emergent discharge to secure the health and safety of Resident #1 and the health and safety of the other residents in the facility. Per interview the IDNS confirmed that the State regulatory agency was not notified of the need to utilize an emergent discharge for Resident #1 on 9/26/12. Per review of the clinical record on 1/30/13, the IDNS confirmed that there was no specific documentation per the regulatory requirements from the physician indicating the specific behaviors of Resident #1 and how his/her health and safety was at risk along with the health and safety of the other residents that required the need for an emergent discharge. The IDNS also confirmed that there was no documentation by the physician of what interventions were utilized prior to the resident's discharge.

3. Per review of the medical record on 1/23/13, it was documented by an LPN on 10/11/12 at 1:19 AM, Resident #1 slapped/pushed another resident to the floor causing injury. "[The ADNS/DNS] telephoned/made aware of this incident. Instructed by DNS, to telephone MD, get an order to transport to CVH for evaluation."

Per review of the clinical record, it indicated that there was no evidence in the physicians progress notes indicating the emergent need for Resident #1 to be discharged on 10/11/12 to the emergency room because Resident #1's health and safety and the health and safety of the other residents in the facility was at risk. There was also no evidence in the clinical record that the State regulatory agency was notified of the need to utilize and emergent discharge for the health and safety of Resident #1 and the health and safety of the other residents in the facility.

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	<p>Per review of the clinical record by the Interim Director of Nursing (IDNS) on 1/30/13, he/she confirmed that there was no documentation by the facility physician in the clinical record of Resident #1 regarding the need to utilize an emergent discharge to secure the health and safety of Resident #1 and the health and safety of the other residents in the facility. Per interview the IDNS confirmed that the State regulatory agent was not notified of the need to utilize an emergent discharge for Resident #1 on 10/11/12. Per review of the clinical record on 1/30/13, the IDNS confirmed that there was no specific documentation per the regulatory requirements from the physician indicating the specific behaviors of Resident #1 and how he/she's health and safety was at risk along with the health and safety of the other residents that required the need for an emergent discharge. The IDNS also confirmed that there was no documentation by the physician of what interventions were utilized prior to the resident's discharge.</p>			