

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

November 14, 2012

Mr. Timothy Urich, Administrator  
Rutland Healthcare And Rehabilitation Center  
46 Nichols Street  
Rutland, VT 05701-3275

Dear Mr. Urich:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 10, 2012**. 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:jl



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

RECEIVED  
Division of

PRINTED: 10/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	NOV 2 12 Licensing and Protection	(X3) DATE SURVEY COMPLETED  C 10/10/2012
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NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET RUTLAND, VT 05701</b>
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F 000	INITIAL COMMENTS	F 000		
F 223 SS=G	<p>An unannounced on-site facility reported complaint investigation was conducted on 10/10/2012 by The Division of Licensing and Protection. The regulatory deficiencies are as follows:</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that 2 of 3 residents identified (Resident #2 and 3) were free from verbal, sexual, physical, and mental abuse. The findings include:</p> <p>1. Per review of the facilities internal investigation, on 10/10/12, Resident #3 was admitted to the facility on 5/20/11, with diagnoses that include: depression, anxiety with hallucinations, agitation and dementia with moderate retardation. The facility's internal investigation dated 5/30/12 indicates that on 5/23/12 a facility staff member (Staff #1) reported that at approximately 1:50 PM, Staff #1 overheard a Licensed Nursing Assistant (LNA), speak to Resident #3 in a harsh tone and overheard the LNA say to Resident #3, you need to get out of bed. Staff #1 then indicates that</p>	F 223	<p>Plan of Correction F 223</p> <p><u>Corrective Action:</u> For Resident #3, a complete internal investigation was conducted and the staff member alleged to have mistreated the resident was terminated prior to any further interaction with the resident. For Resident #2, a complete internal investigation was conducted and the staff member alleged to have mistreated the resident was terminated prior to any further interaction with the resident.</p> <p><u>Identify Other Potential Residents:</u> In order to identify others with the potential to be affected by the alleged deficient practice, the facility will interview three residents per unit per week to ensure compliance with the facility Abuse Prohibition Policy.</p> <p><u>Systemic Changes:</u> Staff will attend mandatory education regarding the Genesis Healthcare Abuse Prohibition policy.</p> <p><u>Monitoring:</u> Audits will be completed monthly x 3 months on incident accident reports to ensure compliance with proper reporting requirements. Results will be reviewed at QI Committee meeting for further evaluation and recommendation.</p> <p><u>Responsibility:</u> Director of Nursing <u>Completion Date:</u> 11/10/2012</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Admin.</i>	(X6) DATE 10/31/12
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

*PMC*

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F 223	<p>Continued From page 1</p> <p>he/she witnessed the LNA grab Resident #3's lower legs just below the knee and threw them over the side of the bed. Staff #1 also indicates that he/she witnessed the LNA grab the wrists of Resident #3 and threw them onto the walker of Resident #3 and heard the LNA yell at Resident #3, you need to get up and go to the bathroom. Staff #1 indicates that he/she heard Resident #3 say twice, "stop beating me up". Staff #1 indicates that he/she then heard the LNA reply to Resident #3 "yeah, I am the one beating you up, you're the one that asked for help, now you need to get up".</p> <p>Per the internal investigation, Resident #3 confirmed in interview with the facility administrator on 5/23/12 that the LNA was "mean", and that the LNA "grabbed my wrist and hurt it." Resident #3 and Staff #1 re-enacted how the LNA transferred Resident #3 out of bed. Resident #3 confirmed that the LNA had "thrown [his/her] legs to the side of the bed" and Resident #3 confirmed that the LNA "yanked on [him/her]" from a lying position. Resident #3 also confirmed that he/she was "afraid of the LNA and doesn't want the LNA to take care of [him/her]."</p> <p>Per review of the facility's internal investigation, the investigation found that the interaction between the LNA and Resident #3 was determined to be at a minimum "abrasive, disrespectful" and that the interaction between the LNA and Resident #3 "negatively impacted the resident's emotional status as the resident stated that [he/she] was afraid of the LNA." Per interview with the facility administrator on 10/10/12, he/she confirmed that the facility felt that based on the internal investigation that Resident #3 was a victim of abuse.</p>	F 223	<p>F223 POC accepted 11/6/12 Mculchaun RN/PMC</p>	

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F 223	<p>Continued From page 2</p> <p>2. Per review of the facility's internal investigation on 10/10/12, Resident #2 was admitted 5/31/12 with diagnoses that included: fractured sacrum/coccyx, pain, depressive disorder and anxiety. Resident #2 was admitted to the facility for pain control and rehabilitation with plans to discharge to home.</p> <p>Per the facility's internal investigation dated 6/13/12, on 6/12/12 at approximately 2:00 AM as per an interview with Resident #2, an Licensed Nursing Assistant (LNA), came into Resident #2's room to assist the resident in transferring to the bathroom. Per Resident #2, he/she indicated that during the transfer the resident felt "hurried by the aide and I can't be hurried." The resident indicated that when the aide and Resident #2 got to the bathroom, the aide let go of the resident to "primp" herself in the mirror, Resident #2 attempted to reach for the handicap bar to sit on the toilet and missed the bar. The resident indicated she lost his/her balance and nearly fell but made it to the seat safely. The aide saw this and said "Jesus Christ!" The aide then said to Resident #2 "that's it, you are using the bed pan from now on." The resident indicated that he/she told the aide that he/she had trouble using the bed pan and the aide said "I don't care, you're going to use the bed pan from now on at night". The resident then indicated that when the aide transferred Resident #2 back to bed the resident began to cry and the aide said "Why are you crying, you are a grown adult".</p> <p>Per review of the internal investigation, the facility found that Resident #2 was an alert and oriented resident and reported the incident that occurred</p>	F 223		

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F 223	Continued From page 3 between Resident #2 and the LNA in fairly great detail. The investigation also indicates that Resident #2 was quite emotional when recalling the event on 6/12/12. The facility investigation indicates that whatever the specific elements of the interaction between the LNA and Resident #2, the LNA negatively impacted Resident #2's emotional status, and that Resident #2 requested that he/she did not want the LNA to care for him/her again. Per interview with the facility administrator on 10/10/12, he/she confirmed that the facility felt that based on the internal investigation that Resident #2 was a victim of abuse.	F 223	Plan of Correction F 225
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	<u>Corrective Action:</u> For the resident identified, the incident was reported, the facility conducted an internal investigation and appropriate action was taken.  <u>Identify Other Potential Residents:</u> In order to identify others with the potential to be affected by the alleged deficient practice, the facility will conduct a daily review of incident and accident reports to ensure compliance with reporting requirements.  <u>Systemic Changes:</u> Staff will attend mandatory education regarding the Genesis Healthcare Abuse Prohibition policy.  <u>Monitoring:</u> Audits will be completed monthly x 3 months on all incident accident reports to ensure compliance with proper reporting requirements. Results will be reviewed at QI Committee meeting for further evaluation and recommendation.  <u>Responsibility:</u> Director of Nursing <u>Completion Date:</u> 11/10/2012

*F225 POC accepted 11/6/12  
McLennan RN/PMC*

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F 225	<p>Continued From page 4</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that all alleged violations involving mistreatment, neglect or abuse are reported immediately to the facility administrator for 1 of 3 residents (Resident #1) identified. The findings include:</p> <p>1. Per review of the facility internal investigation dated 4/23/12, a facility housekeeper allegedly observed a facility Registered Nurse (RN) in the hallway with Resident #1 on 4/10/12 at approximately 1:30 PM. The housekeeper alleged that Resident #1 was standing from his/her wheelchair, causing the chair alarm to sound. The housekeeper alleged that the RN told Resident #1 to "sit down, you know you can't get up you stupid...idiot."</p> <p>Per the internal investigation, on 4/16/2012 the facility administrator interviewed the</p>	F 225		

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F 225	<p>Continued From page 5</p> <p>housekeeper, during the interview the housekeeper confirmed to the administrator that the alleged incident occurred on 4/10/12, 6 days prior to the housekeeper's report to the facility administrator. Per the facility's internal investigation, the housekeeper confirmed on 4/16/12 that he/she realized that the alleged incident should have been reported immediately to the facility administrator but the housekeeper was nervous to do so. Per interview with the facility administrator on 10/10/2012, he/she confirmed that on 4/16/2012 the facility housekeeper reported an alleged abuse to him/her and that the housekeeper acknowledged that the alleged incident of abuse actually occurred 6 days prior to the housekeeper's reporting. Per the facility administrator it is the expectation of the administrator that all employees that observe and alleged incident of abuse must report this to the facility administrator immediately. Per interview, the administrator confirmed that the housekeeper was a new employee who had received appropriate training on abuse, neglect and mistreatment reporting requirements.</p> <p>Per review of the housekeepers employee file on 10/10/12, there was evidence that the facility had provided appropriate training to the housekeeper on 3/23/12 regarding abuse, neglect and mistreatment reporting. Per review of the facility's policy and procedure titled; Abuse Prohibition, the policy indicates that "anyone who witnesses an incident of suspected abuse neglect, involuntary seclusion, injuries of unknown origin, or misappropriation or resident property is to tell the abuser to stop immediately and report the incident to his/her supervisor</p>	F 225		

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F 225 F 226 SS=E	<p>Continued From page 6 immediately."</p> <p>483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit 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 to implement it's own policy and procedure that prohibits mistreatment, neglect and abuse of residents for 3 of 3 residents (#1, #2 and #3) identified in the sample. The findings include:</p> <p>1. Per record review and interview, Resident #3 was a victim of abusive actions by a Licensed Nursing Assistant (LNA) on 5/23/12. The facility's internal investigation found that the interaction between the LNA and Resident #3 was determined to be at a minimum "abrasive, disrespectful" and that the interaction between the LNA and Resident #3 "negatively impacted the resident's emotional status as the resident stated that [he/she] was afraid of the LNA." The investigation indicates that the LNA was terminated from employment.</p> <p>Per review of the facility's policy and procedure titled; Abuse Prohibition, the policy indicates that all reports of suspected abuse be reported to the attending physician and the facility will protect residents from further harm during an</p>	F 225 F 226	<p>Plan of Correction F 226</p> <p><u>Corrective Action:</u> For each resident identified, an assessment will be completed and the respective care plans will be updated as necessary.</p> <p><u>Identify Other Potential Residents:</u> To ensure compliance with the facility's Resident Abuse Prohibition policy the following will be completed: (1) Random interviews of staff regarding the facility policy will be conducted. (2) The facility will interview three residents per unit per week to ensure compliance with the facility Abuse Prohibition Policy.</p> <p><u>Systemic Changes:</u> Staff will attend mandatory education regarding the Genesis Healthcare Abuse Prohibition</p> <p><u>Monitoring:</u> Staff and resident interviews will be conducted weekly x 1 month and then monthly x 3 months. Results will be reviewed at Q1 committee for further evaluation and recommendations'</p> <p><b>Responsibility:</b> Director of Nursing <b>Completion Date:</b> 11/10/2012</p> <p><i>F226 POL accepted 11/6/12 McLinnan RN/PMC</i></p>

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F 226	<p>Continued From page 7</p> <p>investigation by, "assigning a representative from Social Services or a designee to monitor the resident's feelings concerning the incident, as well as the resident's involvement in the investigation."</p> <p>Per review of the medical record on 10/10/12, there was no evidence that Resident #3 was evaluated by Social Services or Psychological Services for changes to his/her emotional status after being the victim of alleged abuse. Per review of the medical record on 10/10/12, there was no documentation that the primary physician for Resident #3 was notified of the alleged abuse to Resident #3.</p> <p>Per interview with the Social Service Director (SSD) on 10/10/12 at 3:54 PM, he/she confirmed that Resident #3 has diagnoses of anxiety, depression and mental retardation and that this places Resident #3 at risk for emotional issues concerning being the victim of verbal and physical abuse. The SSD also confirmed that Resident #3 should have been assessed by Social Services, Psychological Services or Medical Services post the incident and Resident #3 was not.</p> <p>Per interview with the facility administrator on 10/10/10 at 3:54 PM, he/she confirmed that the facility policy indicated that the facility will protect residents from further harm during an investigation by, "assigning a representative from Social Services or a designee to monitor the resident's feelings concerning the incident, as well as the resident's involvement in the investigation." The Administrator confirmed that no one had evaluated Resident #3 after the alleged abuse.</p>	F 226		

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F 226	<p>Continued From page 8</p> <p>2. Per record review and interview, Resident #2 was a victim of abusive actions by an LNA on 6/12/12. The facility investigation indicates that whatever the specific elements of the interaction between the LNA and Resident #2, the LNA negatively impacted Resident #2's emotional status, and that Resident #2 requested that he/she did not want the LNA to care for him/her again. The facility investigation indicates that the LNA was terminated from his/her position at the facility and the actions of the LNA were reported to the Vermont State Board of Nursing.</p> <p>Per review of the facility's policy and procedure titled; Abuse Prohibition, the policy indicates that all reports of suspected abuse be reported to the attending physician and the facility will protect residents from further harm during an investigation by, "assigning a representative from Social Services or a designee to monitor the resident's feelings concerning the incident, as well as the resident's involvement in the investigation."</p> <p>Per review of the medical record on 10/10/12, there was no evidence that Resident #2 was evaluated by Social Services or Psychological Services for changes to his/her emotional status after being the victim of alleged abuse. Per review of the medical record on 10/10/12, there was no documentation that the primary physician for Resident #2 was notified of the alleged abuse to Resident #2.</p> <p>Per interview with a Social Service employee on 10/10/12 at 11:15 AM, he/she indicated that he/she was not aware of the incident between</p>	F 226		

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F 226	<p>Continued From page 9</p> <p>Resident #2 and the LNA until a few days before discharge when Resident #2 stated to the him/her that Resident #2 was afraid to be discharged because the "fired employee might find out where Resident #2 lived and go there." Per interview with the Social Service Director (SSD) on 10/10/12 at 11:47 AM, the SSD was unable to say when he/she was made aware of the incident between Resident #2 and an LNA on 6/12/12. The SSD reviewed the medical record and confirmed that there was no documentation regarding the incident and no evaluation by Social Services or psychological services of Resident #2 regarding being the victim of alleged abuse. The SSD confirmed that Resident #2 had an extensive history of anxiety and depression and should have been assessed for emotional changes related to being the victim of alleged abuse. The SSD confirmed that Resident #2 did display paranoid behavior and concern after the incident and concern for his/her safety upon discharge.</p> <p>Per interview with the facility administrator on 10/10/10 at 3:54 PM, he/she confirmed that the facility policy indicated that the facility will protect residents from further harm during an investigation by, "assigning a representative from Social Services or a designee to monitor the resident's feelings concerning the incident, as well as the resident's involvement in the investigation." The Administrator confirmed that no one had evaluated Resident #2 after the alleged abuse.</p> <p>3. Per review of the facility internal investigation dated 4/23/12, a facility housekeeper allegedly observed a facility Registered Nurse (RN) in the</p>	F 226		

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F 226	<p>Continued From page 10</p> <p>hallway with Resident #1 on 4/10/12 at approximately 1:30 PM. The housekeeper alleged that Resident #1 was standing from his/her wheelchair, causing the chair alarm to sound. The housekeeper alleged that the RN told Resident #1 to "sit down, you know you can't get up you stupid...idiot."</p> <p>Per the internal investigation, on 4/16/2012 the facility administrator interviewed the housekeeper, during the interview the housekeeper confirmed to the administrator that the alleged incident occurred on 4/10/12, 6 days prior to the housekeeper's report to the facility administrator. Per the facility's internal investigation the housekeeper confirmed on 4/16/12 that he/she realized that the alleged incident should have been reported immediately to the facility administrator but the housekeeper was nervous to do so.</p> <p>Per interview with the facility administrator on 10/10/2012, he/she confirmed that on 4/16/2012 the facility housekeeper reported an alleged abuse to him/her and that the housekeeper acknowledged that the alleged incident of abuse actually occurred 6 days prior to the housekeepers reporting. Per the facility administrator it is the expectation of the administrator that all employees that observe and alleged incident of abuse must report this to the facility administrator immediately. Per interview the administrator, he/she confirmed that the housekeeper was a new employee who had received appropriate training on abuse, neglect and mistreatment reporting requirements.</p> <p>Per review of the facilities policy and procedure</p>	F 226		

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F 226	Continued From page 11 titled; Abuse Prohibition, the policy indicates that "anyone who witnesses an incident of suspected abuse neglect, involuntary seclusion, injuries of unknown origin, or misappropriation or resident property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately."	F 226	Plan of Correction F 241	
F 241 SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to promote care in a manner that maintains or enhances each resident's dignity and respect for 2 of 3 residents (Residents #2 and #3) identified. The findings include:  1. Per review of the facility's internal investigation on 10/10/12, Resident #2 was admitted 5/31/12 with diagnoses that included: fractured sacrum/coccyx, pain, depressive disorder and anxiety. Resident #2 was admitted to the facility for pain control and rehabilitation with plans to discharge to home.  Per the facility's internal investigation dated 6/13/12, on 6/12/12 at approximately 2:00 AM as per an interview with Resident #2, an Licensed Nursing Assistant (LNA), came into Resident #2's room to assist the resident in transferring to the bathroom. Per Resident #2, he/she indicated that	F 241	<u>Corrective Action:</u> For resident #2 the incident was reported, the facility conducted an internal investigation and appropriate action was taken. For Resident #3, the comprehensive care plan will be reviewed and revised per the resident's participation/wishes.  <u>Identify Other Potential Residents:</u> In order to identify others with the potential to be affected by the alleged deficient practice, the facility will review each resident's care plan quarterly, annually, at a significant change or at such time as a resident/responsible party expresses a change in care preference.  <u>Systemic Changes:</u> Staff will attend mandatory education regarding the Genesis Healthcare Abuse Prohibition & Resident Rights policy. Particular emphasis will be placed on resident's dignity, respect and freedom of choice as it relates to their care.  <u>Monitoring:</u> The facility will interview three residents per unit per week to ensure compliance with resident rights and participation in care process. Audits will be completed weekly x 4, then monthly x 3. Results of audits will be reviewed at the QI Committee.  <u>Responsibility:</u> Director of Nursing <u>Completion Date:</u> 11/10/2012	

F241 POC accepted 11/6/12  
McLellan RNF/AME

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F 241	<p>Continued From page 12</p> <p>during the transfer the resident felt "hurried by the aide and I can't be hurried." The resident indicated that when the aide and Resident #2 got to the bathroom, the aide let go of the resident to "primp" herself in the mirror, Resident #2 attempted to reach for the handicap bar to sit on the toilet, and missed the bar. The resident indicated she lost his/her balance and nearly fell but made it to the seat safely. The aide saw this and said "Jesus Christ!" The aide then said to Resident #2 "that's it, you are using the bed pan from now on." The resident indicated that he/she told the aide that he/she had trouble using the bed pan and the aide said "I don't care, you're going to use the bed pan from now on at night". The resident then indicated that when the aide transferred Resident #2 back to bed the resident began to cry and the aide said "Why are you crying, you are a grown adult".</p> <p>Per review of the internal investigation, the facility found that Resident #2 was an alert and oriented resident and reported the incident that occurred between Resident #2 and the LNA in fairly great detail. The investigation also indicates that Resident #2 was quite emotional when recalling the event on 6/12/12. The facility investigation indicates that whatever the specific elements of the interaction between the LNA and Resident #2, the LNA negatively impacted Resident #2's emotional status, and that Resident #2 requested that he/she did not want the LNA to care for him/her again.</p> <p>Per interview with the facility administrator on 10/10/12, he/she confirmed that Resident #2's dignity had been effected by the actions of the LNA on 6/12/12.</p>	F 241		
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F 241

Continued From page 13

2. Per review of the facilities internal investigation, on 10/10/12, Resident #3 was admitted to the facility on 5/20/11, with diagnoses that include: depression, anxiety with hallucinations, agitation and dementia with moderate retardation. The facility's internal investigation dated 5/20/12 indicates that on 5/23/12 a facility staff member (Staff #1) reported that at approximately 1:50 PM, Staff #1 overheard a Licensed Nursing Assistant (LNA), speak to Resident #3 in a harsh tone and overheard the LNA say to Resident #3, you need to get out of bed. Staff #1 then indicates that he/she witnessed the LNA grab Resident #3's lower legs just below the knee and threw them over the side of the bed. Staff #1 also indicates that he/she witnessed the LNA grab the wrists of Resident #3 and threw them onto the walker of Resident #3 and heard the LNA yell at Resident #3, you need to get up and go to the bathroom. Staff #1 indicates that he/she heard Resident #3 say twice, "stop beating me up". Staff #1 indicates that he/she then heard the LNA reply to Resident #3 "yeah, I am the one beating you up, you're the one that asked for help, now you need to get up".

Per the internal investigation, Resident #3 confirmed in interview with the facility administrator on 5/23/12 that the LNA was "mean", and that the LNA "grabbed my wrist and hurt it." Resident #3 and Staff #1 re-enacted how the LNA transferred Resident #3 out of bed. Resident #3 confirmed that the LNA had "thrown [his/her] legs to the side of the bed" and Resident #3 confirmed that the LNA "yanked on [him/her]" from a lying position. Resident #3 also confirmed that he/she was "afraid of the LNA and doesn't want the LNA to take care of [him/her]."

F 241



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F 250	<p>Continued From page 15</p> <p>investigation indicates that the LNA was terminated from employment.</p> <p>Per review of the facility's policy and procedure titled; Abuse Prohibition, the policy indicates that all reports of suspected abuse be reported to the attending physician and the facility will protect residents from further harm during an investigation by, "assigning a representative from Social Services or a designee to monitor the resident's feelings concerning the incident, as well as the resident's involvement in the investigation."</p> <p>Per review of the medical record on 10/10/12, there was no evidence that Resident #3 was evaluated by Social Services or Psychological Services for changes to his/her emotional status after being the victim of alleged abuse. Per review of the medical record on 10/10/12, there was no documentation that the primary physician for Resident #3 was notified of the alleged abuse to Resident #3.</p> <p>Per review of the comprehensive care plan for Resident #3, there was no documentation that the care plan was updated to reflect resident specific interventions related to Resident #3 being the victim of abuse with a history of depression, anxiety with hallucinations, agitation and dementia with moderate retardation.</p> <p>Per interview with the Social Service Director (SSD) on 10/10/12 at 3:54 PM, he/she confirmed that Resident #3 has diagnoses of anxiety, depression and mental retardation and that this places Resident #3 at risk for emotional issues concerning being the victim of verbal and physical</p>	F 250		
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F 250	<p>Continued From page 16</p> <p>abuse. The SSD also confirmed that Resident #3 should have been assessed by Social Services, Psychological Services or Medical Services post the incident and Resident #3 was not.</p> <p>Per interview with the facility administrator on 10/10/10 at 3:54 PM, he/she confirmed that no one had evaluated Resident #3 after the alleged abuse.</p> <p>2. Per record review and interview, Resident #2 was a victim of abusive actions by an LNA on 6/12/12. The facility investigation indicates that whatever the specific elements of the interaction between the LNA and Resident #2, the LNA negatively impacted Resident #2's emotional status, and that Resident #2 requested that he/she did not want the LNA to care for him/her again. The facility investigation indicates that the LNA was terminated from his/her position at the facility and the actions of the LNA were reported to the Vermont State Board of Nursing.</p> <p>Per review of the facility's policy and procedure titled; Abuse Prohibition, the policy indicates that all reports of suspected abuse be reported to the attending physician and the facility will protect residents from further harm during an investigation by, "assigning a representative from Social Services or a designee to monitor the resident's feelings concerning the incident, as well as the resident's involvement in the investigation."</p> <p>Per review of the medical record on 10/10/12, there was no evidence that Resident #2 was evaluated by Social Services or Psychological Services for changes to his/her emptional status</p>	F 250		

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F 250	<p>Continued From page 17</p> <p>after being the victim of alleged abuse. Per review of the medical record on 10/10/12, there was no documentation that the primary physician for Resident #2 was notified of the alleged abuse to Resident #2.</p> <p>Per review of the comprehensive care plan for Resident #2, there was no documentation that the care plan was updated to reflect resident specific interventions related to Resident #2 being the victim of alleged abuse with a history of depressive disorder and anxiety. Per interview on 10/10/12 at 11:47 AM the SSD confirmed after review of the comprehensive care plan that the care plan was not revised with resident specific interventions to address the needs of an alleged abuse victim.</p> <p>Per interview with a Social Service employee on 10/10/12 at 11:15 AM, he/she indicated that he/she was not aware of the incident between Resident #2 and the LNA until a few days before discharge when Resident #2 stated to the him/her that Resident #2 was afraid to be discharged because the "fired employee might find out where Resident #2 lived and go there." Per interview with the Social Service Director (SSD) on 10/10/12 at 11:47 AM, the SSD was unable to say when he/she was made aware of the incident between Resident #2 and an LNA on 6/12/12. The SSD reviewed the medical record and confirmed that there was no documentation regarding the incident and no evaluation by Social Services or psychological services of Resident #2 regarding being the victim of alleged abuse. The SSD confirmed that Resident #2 had an extensive history of anxiety and depression and should have been assessed for emotional</p>	F 250		

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F 250	Continued From page 18 changes related to being the victim of alleged abuse. The SSD confirmed that Resident #2 did display paranoid behavior and concern after the incident and concern for his/her safety upon discharge.  Per interview with the facility administrator on 10/10/10 at 3:54 PM, he/she confirmed that no one had evaluated Resident #2 after the alleged abuse.	F 250	Plan of Correction F 280  <u>Corrective Action:</u> The care plan for the identified residents shall be reviewed and updated in accordance with the RAI process or as a significant change occurs.  <u>Identify Other Potential Residents:</u> In order to identify others with the potential to be affected by the same alleged deficient practice, resident care plans will be reviewed and updated in accordance with the RAI process or as a significant change occurs.  <u>Systemic Changes:</u> Licensed staff as well as the center IDT will be educated to Genesis Policy regarding Care Plan Implementation and Revision.  <u>Monitoring:</u> Audits will be completed for resident care plans to ensure compliance with implementation and revision of care plans. These audits will be completed monthly x3 months. Results will be reviewed at QI Committee meeting for further evaluation and recommendation.  <u>Responsibility:</u> Director of Nursing <u>Completion Date:</u> 11/10/2012
F 280 SS=D	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	F 280	

F280 PDC accepted 11/10/12  
McWilliam RN/PMC

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F 280	<p>Continued From page 19</p> <p>facility failed review and revise the care plan of 2 of 3 residents (Resident #2 and #3) with resident specific interventions to meet the needs of residents who were victims of abuse. Findings include:</p> <p>1. Per record review and interview, Resident #3 was a victim of abusive actions by a Licensed Nursing Assistant (LNA) on 5/23/12. The facility's internal investigation found that the interaction between the LNA and Resident #3 was determined to be at a minimum "abrasive, disrespectful" and that the interaction between the LNA and Resident #3 "negatively impacted the resident's emotional status as the resident stated that [he/she] was afraid of the LNA."</p> <p>Per review of the comprehensive care plan for Resident #3, there was no documentation that the care plan was updated to reflect resident specific interventions related to Resident #3 being the victim of abuse with a history of depression, anxiety with hallucinations, agitation and dementia with moderate retardation.</p> <p>Per interview with the Social Service Director (SSD) on 10/10/12 at 3:54 PM, he/she confirmed that Resident #3 has diagnoses of anxiety, depression and mental retardation and that this places Resident #3 at risk for emotional issues concerning being the victim of verbal and physical abuse.</p> <p>2. Per record review and interview, Resident #2 was a victim of abusive actions by an LNA on 6/12/12. The facility investigation indicates that whatever the specific elements of the interaction between the LNA and Resident #2, the LNA</p>	F 280		
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F 280	Continued From page 20 negatively impacted Resident #2's emotional status, and that Resident #2 requested that he/she did not want the LNA to care for him/her again.  Per review of the comprehensive care plan for Resident #2, there was no documentation that the care plan was updated to reflect resident specific interventions related to Resident #2 being the victim of alleged abuse with a history of depressive disorder and anxiety. Per interview on 10/10/12 at 11:47 AM the SSD confirmed after review of the comprehensive care plan that the care plan was not revised with resident specific interventions to address the needs of an alleged abuse victim.	F 280		