

Division of Licensing and Protection  
103 South Main Street  
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

October 23, 2015

Mr. Thomas Rice, Administrator  
Brookside Health And Rehabilitation  
1200 Christian Street  
White River Junction, VT 05001-9267

**RE: Complaint Survey Findings - Past Non-Compliance**

Dear Mr. Rice:

On **October 8, 2015**, the Division of Licensing and Protection, completed a complaint investigation at Brookside Health And Rehabilitation. As a result of that survey, the Division determined that at a point in time prior to the date of our visit you were not in substantial compliance with the federal regulations applicable to long term care facilities.

Statement of Deficiencies Form CMS 2567

Enclosed is a statement of deficiency generated as a result of the survey. All references to regulatory requirements in the enclosure and in this letter are found in Title 42, Code of Federal Regulations. As the cited deficiency was corrected at the time of our visit, no plan of correction is required.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies to Suzanne Leavitt RN, MS, Assistant Division Director, Division of Licensing and Protection. **This written request must be received by this office by November 4, 2015.**

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

|  |   |   |   |                      |   |
|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                               |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>475010</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>10/08/2015</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BROOKSIDE HEALTH AND REHABILITATION</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1200 CHRISTIAN STREET</b><br><b>WHITE RIVER JUNCTION, VT 05001</b>  |                      |   |
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| F 000  | INITIAL COMMENTS  | F 000   |   |                      |   |
| F 223<br>SS=G  | <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:<br/>Based on record review, resident and staff interview, the facility failed to ensure that all residents were free from abuse for 2 of 4 residents sampled. (Residents #1, #2). Findings include:</p> <p>1. Per record review on 10/7 -10/8/15, Resident #1 told the nurse on duty that they were "scared to death" of one of the LNAs, and they provided a description of the staff member and a name, but no specific allegations of verbal abuse. Approximately 10 minutes later, the same nurse walked in on an encounter with the same LNA and Resident #2, overhearing the LNA say "shut</p> | F 223   | Past noncompliance: no plan of correction required.   |                      |   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

10/08/2015

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.

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

PRINTED: 07/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

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| F 223  | <p>Continued From page 1</p> <p>up , roll over, and let me do my job". The resident alleges that the LNA had left them on the bedpan for a long time, and that this was painful. The nurse immediately removed the LNA from the floor, and reported the incident to supervisors. The LNA refused to come in and interview with the DNS the following day, and resigned from the position. Per interview on 10/8/15 at 11:40 AM, the DNS confirmed the allegation was reported and investigated, and the employee did not return to the facility.</p> <p>2. Per record review on 10/7 -10/8/15, Resident #2 had an incident with another LNA on 10/1/15. The allegation was that the LNA was transferring the resident from the commode back to the bed, was impatient with the resident ringing the call bell repeatedly, called the resident a "bitch" and purposely kicked the resident in the shin while providing care. The resident was seen crying by one of the nurses, and reported this to the nurse when asked. The LNA was removed from the floor by the nurse, and then alerted the DNS. An incident report written by an RN on 10/1/15 described Resident #2 as having a bruise on their shin that measured 4.5 cm. by 1 cm. with a raised area in the middle. Resident #2 stated that this is where the LNA kicked their shin. MD made a visit to the resident the following day and also noted the bruise. Per observation on 10/7/15, the resident showed me the fading bruise and bump which were still faintly visible, and said that is where the LNA kicked them.</p> <p>3. Per record review on 10/7 -10/8/15, Resident #3 told one of the staff that the LNA that had given them a shower on 10/1/15 had allegedly taken off a dirty brief and hit the resident in the</p> | F 223   |   |                      |   |

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| F 223  | <p>Continued From page 2</p> <p>head with it. The resident was very upset, and named the LNA that was involved. The resident was very adamant that it happened. As this was the same LNA who had been accused of kicking another resident the same day, they had already been removed from the floor. Per interview on 10/8/15 at 11:30 AM, the DNS confirmed that the LNA denied the allegations, however the facility DNS felt there was enough evidence to terminate the employment of the LNA based on residents interviewed.</p> <p>Per review of the corrective actions already taken, and ongoing plan by the facility, the following is noted:</p> <ol style="list-style-type: none"> <li>1. After the recertification survey on 7/8/15, the facility was cited F226 for not following abuse investigation protocols the facility held a mandatory inservice in early August to go over resident rights, abuse reporting, and issues related to abuse prohibition as part of their survey plan of correction.</li> <li>2. After the alleged incidents were reported on 10/1/15, the facility held an inservice on 10/2/15 for Unit Managers/Supervisors, Head of Activities, Social Services, and a couple of the senior LNAs to go over the reporting requirements and recognizing abuse/neglect of residents. There will be a mandatory inservice for all other staff this week 10/12- 10/16/15 to go over the definitions of abuse, the requirements of reporting, and to talk about staff stress and interventions for relieving tensions during work.</li> <li>3. Unit Manager and DNS are insisting that all staff on duty take their 1/2 hour break during</li> </ol> | F 223   |   |                      |   |

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| F 223  | <p>Continued From page 3</p> <p>their shift, even if they are busy. They have developed a schedule to be sure this happens and everyone gets a break for a meal and then a 1/2 hour break. They are reviewing the schedule, and the staffing patterns, and have added another LNA to the wing with the heaviest care needs residents to help out during the busiest hours of the day. They are also informing staff that it is alright for them to tell their supervisor that they are overwhelmed and need help, or are in need of a few minutes to calm down if they are upset. The DNS wants the staff to know it is always acceptable to say they need a break if there is tension. The DNS has encouraged all staff to speak with her if they are having personal problems and need support, or if there is a problem with their workload, a particular resident, or staff to staff conflict.</p> <p>4. The staff who witnessed abuse or heard an allegation from a resident all reported to their supervisors immediately. Staff who were accused of abuse were removed from the floor immediately and did not return to care for residents. The facility reported all incidents to DLP within the required time frame, and completed a thorough internal investigation of each alleged incident. Social Services followed up with interviews of alleged victims and offered support. Nursing intervention as appropriate, and care plans were updated with the alleged incidents and interventions as appropriate. Background checks were completed on the employees reviewed, with no negative findings.</p> <p>5. Ongoing audits are being completed from the recertification which included the F226 to assess compliance with investigating and reporting.</p> | F 223   |   |                      |   |

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| F 223  | Continued From page 4<br>Current DNS and Unit Manager are also adding audits related to abuse prohibition, staff satisfaction and stress levels, due to more recent allegations of abuse at the facility. | F 223  |   |   |