

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 2, 2012

Mr. Dane Rank, Administrator
Thompson House Nursing Home
80 Maple Street
Brattleboro, VT 05302

Provider #: 475050

Dear Mr. Rank:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **January 25, 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, MS
Licensing Chief

PC:ne

Enclosure



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

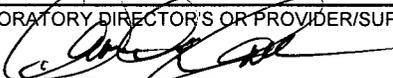
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PRINTED: 02/02/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	Licensing and Protection C 01/25/2012
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NAME OF PROVIDER OR SUPPLIER THOMPSON HOUSE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET BRATTLEBORO, VT 05302
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F 000	INITIAL COMMENTS	F 000		
F 151 SS=D	<p>The Division of Licensing and Protection conducted an unannounced onsite complaint investigation on 1/23/12 and 1/25/12. The following regulatory deficiencies were identified:</p> <p>483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>The facility failed to ensure that one resident reviewed in the sample (Resident #1) was free to exercise his/her rights as a resident of the facility and as a citizen of the United States. The findings include:</p> <p>Based on interview and record review, Resident #1 was isolated for an extended period of time and was limited in the amount of time that the resident could interact with the facility population.</p> <p>1. Per medical record review on 1/23/12, Resident #1 was admitted on 8/13/09, with diagnoses that include depressive disorder and learning disabilities. Per review of Resident #1's medical record, Resident #1 is alert and oriented and per review of the Psychiatric evaluation dated 11/08/11, indicated that Resident #1 "is violent to other residents at times." The evaluation also stated that for Resident #1 there is a "question of</p>	F 151	<p>F 151</p> <p>Resident #1 care plan reviewed to ensure that interventions in place allow for freedom of movement and interaction with others.</p> <p>Resident #1 and family member updated regarding current care plan interventions.</p> <p>All resident care plans reviewed to ensure appropriate interventions in place to respect residents rights.</p> <p>All future temporary interventions for resident to resident altercations will be discussed by the IDT in regular morning meetings until a permanent intervention is implemented or the resident issue is resolved.</p> <p>Policies regarding residents rights were reviewed and updated as necessary.</p> <p>DNS/SDC provided education to all staff regarding maintaining residents rights during interventions for the protection of all residents.</p> <p>DNS or designee will perform audits of resident records following resident to resident</p>	<p>1/27/12</p> <p>2/15/12</p> <p>2/22/12</p> <p>1/27/12 and ongoing</p> <p>2/15/12</p> <p>2/22/12</p> <p>Ongoing</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/14/12
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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.

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F 151	<p>Continued From page 1</p> <p>mental retardation, though [he/she] is quite highly functioning." Review of the admission paperwork, indicates that Resident #1 does not have a legal guardian and per interview with the facility Administrator on 1/25/12, Resident #1 is able to make his/her own decisions.</p> <p>Per the medical record, Resident #1 had physical altercations with other residents on 11/19/11, 12/30/11 and 1/13/12. Per review of the nurse's notes, Resident #1 scratched the face of another resident and the facility's immediate intervention was to confine Resident #1 to his/her room and only allow Resident #1 out of the room for supervised phone calls with staff and supervised activities during the timeframe of 11/19 until 11/28/11 (total of 9 days). Per nurse's notes on 12/30/11, Resident #1 "slapped" the hand of a resident that utilized Resident #1's walker to stabilize his/her self to stand. The facility's immediate intervention was to confine Resident #1 to his/her room for a time period of 12/30/11 to 1/1/12. Resident #1 was allowed out of room only with supervision to utilize the phone. Per review of the nurse's notes dated 1/13/12, Resident #1 "kicked" another resident who was in his/her way and the facility's immediate intervention was to confine Resident #1 to his/her room and allowed to come out to use the phone with supervision from staff and had to have all his/her meals in his/her room over the course of a weekend.</p> <p>Nurse's notes dated 11/19/11 indicate that Resident #1 had been confined to his/her room as a result of an altercation. The day shift Registered Nurse (RN), confirmed in interview on 1/25/12 at 10:13 AM that he/she verbalized to</p>	F 151	<p>altercations to ensure that residents rights are respected.</p> <p>Results will be reported at quarterly QA meetings. DNS to monitor for compliance.</p> <p><i>F151-POC accepted 2/27/12 M. Culhane RN / Pmcotarn</i></p>	Ongoing	

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F 151	<p>Continued From page 2</p> <p>Resident #1 that his/her behavior was "not appropriate" and Resident #1 "could not act out like that" and because of "[his/her] behavior, [he/she] would be confined to [his/her] room for a short period of time until [he/she] could not act out again." Review of the nurse's notes dated 11/26/11, Resident #1 wanted to know "how long [he/she] would have to stay cooped up?" and the nurse indicated to Resident #1 "I am not in charge of making those decisions." Per interview on 1/25/12 at 10:03 AM with the day shift Licensed Nursing Assistant (LNA), he/she confirmed that his/her understanding was that Resident #1 was to stay in his/her room except to use the phone and Resident #1 had to be supervised by staff to use the phone. Per interview with the Activities Director on 1/25/12 at 9:58 AM, he/she confirmed that his/her understanding was that Resident #1 was confined to his/her room because of physical altercations with other residents and that the only time Resident #1 was allowed out of his/her room during confinement was to attend supervised activities.</p> <p>Per interview with Resident #1 on 1/23/12 and again on 1/25/12, Resident #1 verbalized that she had hit people and that he/she had to stay in his/her room as punishment until she/he could learn to behave. Per review of the medical record on 1/25/12 there was no evidence that the "confinement" intervention was discussed with the Resident #1 prior to its utilization. Per interview in 1/25/12 at 12:56 PM with Resident #1's family member, he/she indicated that the facility had informed him/her after two incidences that Resident #1 was being confined but not the third. The family member also indicated that</p>	F 151		

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F 151	Continued From page 3 he/she had attended meetings to discuss Resident #1's "likes and activities" but there were never discussions at these meetings regarding how to manage Resident #1's behavior issues. The family member also indicated that he/she "did not feel that confinement was necessary for punishment, and the facility needs to do something." There was no evidence in the medical record that the facility ensured that Resident #1 understood that he/she could request to be out of his/her room. Per interview on 1/25/12 at 1:15 PM with the facility Administrator and Director of Nursing (DON), they confirmed that Resident #1 had been confined to his/her room as an intervention to stop Resident #1 physically aggressive behavior toward other residents. The Administer and DON were unable to provide any written documentation that Resident #1 had been consulted prior to the confinements on 11/19, 12/30 and 1/13/12. Also, there was no evidence that Resident #1 was advised of his/her rights of participation, length of time of the confinements or long term plan to help Resident #1 manage his/her interactions with facility residents.	F 151		
F 223 SS=E	483.13(b), 483.13(b)(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. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.	F 223	F223 Resident #1 care plan reviewed to ensure that interventions in place allow for freedom of movement and interaction with others. Resident #1 and family member updated regarding current care plan interventions.	2/13/12 2/15/12

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F 223	Continued From page 4 This REQUIREMENT is not met as evidenced by: The facility failed to ensure that one resident identified in the sample (Resident #1) was free from extended involuntary seclusion as a result of behavior issues and failed to protect 3 of 4 residents reviewed in the sample (Resident #2, #3 and #4) from abuse by another resident. The findings include: Based on interview and record review, the facility involuntarily secluded Resident #1 from the general facility population on three separate occasions for longer than an emergent short-term period of time as a way to control Resident #1's behavior issues. The facility also failed to protect 3 of 4 Residents from physical abuse by another resident. 1. Per medical record review on 1/23/12, Resident #1 was admitted on 8/13/09, with diagnoses that include depressive disorder and learning disabilities. Per the medical record, Resident #1 has had a noted documented history since admission of being physically aggressive toward other residents. Per review of the nurse's notes and the facility's internal investigation, on 11/19/11 Resident #1 admitted to staff to physically "assaulting" Resident #2. Resident #2 had wandered into Resident #1's room and lay down on Resident #1's bed. Resident #1 admitted to scratching Resident #2's face in an attempt to get him/her to leave. Per review of Resident #1's medical record, Resident #1 is alert and oriented and per review of the Psychiatric evaluation dated 11/08/11, indicated that Resident #1 "is violent to other residents at times." The evaluation also	F 223	Resident #1 behavior is reviewed and documented weekly. All incidents of behavior will be reported to the Director of Nursing immediately. All resident care plans reviewed to ensure appropriate interventions in place to respect residents rights. All future temporary interventions for resident to resident altercations will be discussed by the IDT in regular morning meetings until a permanent intervention is implemented or the resident issue is resolved. Policies regarding residents rights were reviewed and updated as necessary. DNS/SDC provided education to all staff regarding residents rights. DNS or designee will perform audits of resident records following resident to resident altercations to ensure that residents rights are respected. Results will be reported at quarterly QA meetings. DNS to monitor for compliance. <i>F223 POC accepted 2/27/12 M. Culihan RN / J. Mettern</i>	1/27/12 and ongoing 2/22/12 1/27/12 and ongoing 2/15/12 2/22/12 Ongoing Ongoing

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F 223	<p>Continued From page 5</p> <p>stated that for Resident #1 there is a "question of mental retardation, though [he/she] is quite highly functioning." Review of the admission paperwork indicates that Resident #1 does not have a legal guardian and per interview with the facility Administrator on 1/25/12, Resident #1 is able to make his/her own decisions.</p> <p>Per interview with Resident #1 on 1/23/12 at 3:00 PM, Resident #1 verbalized that after she/he scratched Resident #2 in the face because he/she would not get off Resident #1's bed and leave the room, Resident #1 was told by staff that "I was being punished and not allowed to come out of my room until I learned how to behave." Per interview with a day shift Licensed Nursing Assistant (LNA) on 1/25/12 at 10:33 AM, the LNA confirmed that Resident #1 was confined to her room for several days for being physical with Resident #2 on 11/19/11 and was not allowed to leave his/her room unless supervised by staff and Resident #1 was only allowed out of room to use phone to call his/her sister and attend some activities with staff. Per interview with a day shift Registered Nurse on 1/25/12 at 10:13 AM, the RN confirmed that Resident #1 had been in an altercation with Resident #2 on 11/19/11 and had been confined to his/her room as a result of the altercation. The RN indicated that he/she verbalized to Resident #1 that his/her behavior was "not appropriate" and Resident #1 "could not act out like that" and because of "[his/her] behavior, [he/she] would be confined to [his/her] room for a short period of time until [he/she] could not act out again." The RN indicated that Resident #1 "was not allowed to eat in the Dining room and when Resident #1 was in the hallway to use the phone, [he/she] had to be with staff."</p>	F 223		

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F 223	Continued From page 6 Review of the nurse's notes dated 11/26/11, Resident #1 wanted to know "how long she/he would have to stay cooped up?" and the nurse indicated to Resident #1 "I am not in charge of making those decisions." Per review of the medical record, Resident #1 remained in his/her room from 11/19/11 to 11/28/11 (total of 9 days), except on four occasions when she was accompanied by staff or family to attend an activity, take a bath and use the phone. Per review of the nurses notes on 11/19/11, there was no evidence that less restrictive interventions were utilized regarding Resident #1's physical aggression toward Resident #2 prior to the utilization of 1:1 supervision and confinement. Per interview with the Activities Director on 1/25/12 at 9:58 AM, he/she indicated that during this time, his/her understanding was that Resident #1 was not allowed out of his/her room without supervision to attend activities. Review of the Activities notes on 1/25/12 there was no evidence that Activities had assessed and evaluated Resident #1 post incidents on 12/30/11 and 1/13/12 and potential needs related to activity participation. Per review of the Social Services (SS) notes for Resident #1, there was no evidence that Resident #1 was assessed and evaluated by SS after the incidents on 12/30/11 and 1/13/12. Per the care plan titled Potential for adjustment and difficult interactions with others, dated with a goal date of 2/17/12, on 11/28/11 " the one on one supervision when out of room (aggression) was discontinued and Resident #1 was moved to another room and is able to be out of room independently." Per interview with the	F 223			

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F 223	<p>Continued From page 7</p> <p>Administrator and Director of Nursing (DON) on 1/25/12 at 1:15 PM, the facility was unable to provide any further documentation regarding resident specific interventions and documentation of a long term plan on how to prevent re-occurrence and protection of potential abuse toward other residents by Resident #1.</p> <p>2. Per review of the nurse's notes on 1/24/12, that on 12/30/11 Resident #1 slapped Resident #3 on the hand when Resident #3 used Resident #1's walker to steady his/her self while attempting to stand. Per record review Resident #3 was admitted to the facility on 2/22/11 with diagnosis that includes advanced dementia with psychosis and combativeness. After the 12/30/11 incident, Resident #1 was again confined to his/her room from 12/30/11 to 1/1/12 and only allowed out of the room with staff to use the phone and attend meals in the dining room. Per interview with day shift LNA on 1/25/12 at 10:33 AM, the LNA confirmed that Resident #1 was again confined to her room for several days unless escorted by staff. Per interview with Resident #1 on 1/25/12, he/she verbalized that after he/she slapped Resident #3, he/she was punished again and had to stay in his/her room except to use the phone and then staff was with him/her. Per review of nursing notes on 12/30/11 there was no evidence that less restrictive interventions were utilized regarding Resident #1's physical aggression toward Resident #3 prior to the utilization of 1:1 supervision and confinement.</p> <p>Per review of the care plan titled Potential for adjustment and difficult interactions with others, dated with a goal date of 2/17/12, on 11/28/11, there was no evidence of resident specific</p>	F 223			

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F 223	Continued From page 8 interventions to address the 12/30/11 incident. Review of the Social Service notes indicated no evidence of the 12/30/11 incident and any resident specific interventions utilized. Per interview with the Administrator and Director of Nursing (DON) on 1/25/12 at 1:15 PM, the facility was unable to provide any further documentation regarding resident specific interventions or documentation of a long term plan on how to prevent re-occurrence and protection of potential abuse toward other residents by Resident #1. 3. Per review of the medical record on 1/23/11, the nurse's notes indicated that on 1/13/11 Resident #1 was seen by staff kicking Resident #4 because Resident #4 was in Resident #1's way. Per record review, Resident #4 was admitted to the facility on 8/21/11 with diagnosis that includes dementia, anxiety and depression. Per the nurse's notes dated 1/13/12, Resident #1 "is to have 1:1 supervision when out of room for telephone use and is to take all meals in his/her room through the weekend." Per interview with the day LNA on 1/25/12, Resident #1 was again confined to his/her room after the 1/13/12 incident for at least 3 days and not allowed out of room without supervision to use the telephone. Per interview with Resident #1 on 1/25/12, he/she indicated that after he/she kicked Resident #4, he/she was on punishment again and could not leave his/her room without the staff to use the phone. Per review of the nurses notes dated 1/13/12, there was no evidence that less restrictive interventions were utilized regarding Resident #1's physical aggression toward Resident #4 prior to the utilization of 1:1 supervision and confinement.	F 223			

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F 223	Continued From page 9 Per review of the care plan titled Potential for adjustment and difficult interactions with others, dated with a goal date of 2/17/12, there was no evidence of resident specific interventions regarding the 1/13/12 incident. Review of the Social Service notes indicated no evidence of the 1/13/12 incident and any resident specific interventions utilized. Per interview with the Administrator and Director of Nursing (DON) on 1/25/12 at 1:15 PM, the facility was unable to provide any further documentation regarding resident specific interventions or documentation of a long term plan on how to prevent re-occurrence and protection of potential abuse toward other residents by Resident #1.	F 223		
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: The facility failed to provide medically- related social services to attain the highest practicable physical, mental and psychosocial well-being, for 4 of 4 residents (Resident #1, #2, #3 and #4) who were involved in physical altercations. The findings include: Based on interview and medical record review the facility failed to ensure the mental and psychosocial well-being for four residents who were participants in physical altercations with	F 250	F 250 All future temporary interventions for resident to resident altercations will be discussed by the IDT in regular morning meetings until a permanent intervention is implemented or the resident issue is resolved. During these meetings SS designee will report on assessments of resident well-being and feelings of safety within the facility and follow-up assessments and coordination with family and other departments. The Administrator or designee will audit SS section of resident chart to ensure proper documentation. Any inconsistencies or omissions of SS assessment and charting related to resident to resident altercations will be noted at the QA meeting quarterly for follow-up. <i>F250 POC accepted 2/27/12 m. culihan RN / Pmcotaren</i>	1/27/12 and ongoing 2/15/12 2/15/12 2/15/12 and ongoing

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F 250	<p>Continued From page 10 another resident.</p> <p>1. Per medical record review on 1/23/12, Resident #1 was admitted on 8/13/09, with diagnoses that include depressive disorder and learning disabilities. Per the medical record, Resident #1 had physical altercations with other residents on 11/19/11, 12/30/11 and 1/13/12. Per review of the nurse's notes, Resident #1 scratched the face of another resident and the facility's immediate intervention was to confine Resident #1 to his/her room and only allow Resident #1 out for supervised phone calls with staff and supervised activities during the timeframe of 11/19 until 11/28/11 (total 9 days). Per nurse's notes on 12/30/11, Resident #1 "slapped" the hand of a resident that utilized Resident #1's walker to stabilize his/her self to stand. The facility's immediate intervention was to confine Resident #1 to his/her room for a time period of 12/30/11 to 1/1/12. Resident #1 was allowed out of room only with supervision to utilize the phone. Per review of the nurse's notes dated 1/13/12, Resident #1 "kicked" another resident who was in his/her way and the facility's immediate intervention was to confine Resident #1 to his/her room and allowed to come out to use the phone with supervision from staff and had to have all his/her meals in his/her room over the course of a weekend.</p> <p>Per review of the Social Services (SS) notes for Resident #1, there was no evidence that Resident #1 was assessed and evaluated by SS after the incident on 12/30/11 or 1/13/12. Per interview with the SS Director on 1/23/12, he/she confirmed that he/she was made aware of the resident to resident altercation on 12/30/11 and</p>	F 250			

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F 250	<p>Continued From page 11</p> <p>1/13/12 and that he/she did not follow-up with Resident #1 post incidence to assess and evaluate the resident's mental and psychosocial well being. Per review of the medical record on 1/25/12, there was no evidence in the SS notes that Resident #1 had been consulted prior to the confinements on 11/19/11, 12/30/11 and 1/13/12 and advised of his/her rights of participation, length of time or long term plan to help Resident #1 manage his/her interactions with facility residents.</p> <p>2. Per review of the medical record, Resident #2 was admitted on 7/5/05, with diagnoses that include persistent mental disorder, dementia with behaviors and wandering. Per review of the nurse's notes on 1/23/12 at 10:03 AM, the nurses documented on 11/19/11 that Resident #2 was found in the room of Resident #1 with scratches to his/her face that extended downward from his/her forehead. Review of the internal investigation by the facility, dated 11/19/11, indicated that Resident #2 was scratched in the face by Resident #1 after wandering into Resident #1's room and laying down on Resident #1's bed. Per the medical record, Resident #1 has a long history since admission of being physically aggressive toward other residents.</p> <p>Per review of the nurses' notes dated 11/19/11 at 10:00 PM, Resident #2 was "not wandering the halls this evening per [his/her] norm and [he/she] presented as being pensive." On 11/20/11 at 11:00 PM the nurse's notes reflect that Resident #2 "presented again this evening as pensive, not smiling or laughing as was [his/her] norm in the evening." On 11/21/11, the note documented that "up in the am per usual, more</p>	F 250			

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F 250	<p>Continued From page 12</p> <p>quiet, not [his/her] usual giggling.", "very sullen." Per review of the Social Services (SS) notes for Resident #2, there was no evidence that Resident #2 was assessed and evaluated by SS after the incident on 11/19/11 as the victim of an altercation or any evidence that SS addressed Resident #2's temporary change in behavior post assault. Per interview with the SS Director on 1/23/12, he/she confirmed that he/she was made aware of the resident to resident altercation on 11/19/11 and that he/she did not follow-up with Resident #2 post incident to assess and evaluate the resident's mental and psychosocial well being.</p> <p>3. Per review of the medical record on 1/25/12, Resident #3 was admitted to the facility on 2/22/11 with diagnoses that include advanced dementia with psychosis and combativeness. On 12/30/11 Resident #3 was in the dining-room and stood up before dinner, steadied his/her self by holding on to the walker of Resident #1, Resident #1 told Resident #3 to sit down and then Resident #1 slapped the back of Resident #3's hand. The nurse's note indicated that SS Director was made aware of incident. Review of the SS notes there was no evidence that Resident #3 was assessed and evaluated by SS after the incident on 12/30/11 as the victim of an altercation. Per interview with the SS Director on 1/25/12, he/she confirmed that he/she was made aware of the resident to resident altercation on 12/30/11 and that he/she did not follow-up with Resident #3 post incident to assess and evaluate the resident's mental and psychosocial well being.</p> <p>4. Per review of the medical record for Resident #4 on 1/25/12, Resident #4 was admitted on</p>	F 250			

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F 250	Continued From page 13 8/21/11 with diagnoses that include dementia, anxiety and depression. Per the nurse's notes on 1/13/12, Resident #1 was observed by staff "kicking" Resident #4 because Resident #4 was in the way when Resident #1 was trying to pass. Review of the SS notes showed that there was no evidence that Resident #4 was assessed and evaluated by SS after the incident on 1/13/12 as the victim of a physical altercation with another resident. Per interview with the SS Director on 1/25/12, he/she confirmed that he/she was made aware of the resident to resident altercation and that he/she did not follow-up with Resident #4 post incident to assess and evaluate the residents mental and psychosocial well being.	F 250		
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.	F 280	F 280 Resident #1 care plan reviewed to ensure that interventions in place allow for freedom of movement and interaction with others. Resident #1 and family member updated regarding current care plan interventions. All resident care plans were reviewed to ensure appropriate updates are included. Policies regarding care planning were reviewed and updated as necessary. DNS/SDC provided education to staff involved in care planning. DNS or designee will perform audits of 5 resident care plans per quarter to ensure that updates are completed as necessary. Results will be reported at QA meetings. DNS to monitor for compliance. <i>F280 POC accepted 2/13/12 M. Cullen RN / R. Mota RN</i>	2/13/12 2/15/12 2/22/12 2/15/12 2/22/12 Ongoing Ongoing

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F 280	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to revise the comprehensive care plan that includes measurable objectives and timetables to meet the each resident's medical, nursing, mental and psychosocial needs for 1 of 4 residents reviewed in the sample (Resident #1). The findings include: The facility failed to revise the comprehensive care plan after two separate incidents of resident to resident physical aggression, and the confinement of Resident #1 on 12/30/11 and 1/13/12. Per medical record review on 1/23/12, Resident #1 was admitted on 8/13/09, with diagnoses that include depressive disorder and learning disabilities. Per the medical record, Resident #1 had physical altercations with other residents on 11/19/11, 12/30/11 and 1/13/12. Per review of the nurse's notes, Resident #1 scratched the face of another resident and the facility's immediate intervention was to confine Resident #1 to his/her room and only allow Resident #1 out for supervised phone calls with staff and supervised activities during the timeframe of 11/19 until 11/28/11 (total of 9 days). Per nurse's notes on 12/30/11, Resident #1 "slapped" the hand of a resident that utilized Resident #1's walker to stabilize his/her self to stand. Resident #1 was confined to his/her room for a time period of 12/30/11 to 1/1/11. Resident #1 was allowed out of room only with supervision to utilize the phone. Per review of the nurse's notes dated 1/13/12,	F 280			

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F 280	<p>Continued From page 15</p> <p>Resident #1 "kicked" another resident who was in his/her way and the facility's immediate intervention was to confine Resident #1 to his/her room and allowed to come out to use the phone with supervision from staff and had to have all his/her meals in his/her room over the course of a weekend.</p> <p>Review of the comprehensive care plan titled Potential for adjustment, difficult interaction with others, with a goal date of 2/17/12, it indicated that on 11/19/11 resident was to receive checks every 15 minutes for suicidal verbalization, 1:1 if out of room (aggression) and these interventions were discontinued on 11/28/11. The other entry dated 11/28/11 indicated that resident was moved to a new room and is "able to be out of room independently, monitor whereabouts as needed." There are no revisions made to the care plan concerning the altercations that occurred on 12/30/11 and 1/13/12 and no resident specific interventions to assist resident in preventing physical aggression or any interventions regarding the periods of confinement due to resident's behaviors.</p> <p>Review of the activities care plan titled potential for social isolation, with a goal date noted as 2/17/12, the last update made on 11/21/11 indicates 1:1 activities 4 times a week when needing supervision at activities. There is no evidence that the care plan was revised to reflect any interventions post the incidents on 12/30/11 or 1/13/12 to prevent further isolation during periods of confinement. Per interview on 1/25/12 at 1:15 PM with the facility Administrator and Director of Nursing (DON), they confirmed that Resident #1 had been confined to his/her room</p>	F 280			

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F 280	Continued From page 16 as an intervention to stop Resident #1 physically aggressive behavior toward other residents. The Administer and DON were unable to provide any written documentation that Resident #1 had been consulted prior to the confinements on 11/19/11, 12/30/11 and 1/13/12 and advised of his/her rights of participation, length of time or long term plan to help Resident #1 manage his/her interactions with facility residents.	F 280	F 282 Resident #2 care plan was reviewed to ensure current interventions are appropriate.	2/15/12
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: The facility failed to implement the comprehensive care plan for 1 of 4 residents reviewed in the sample (Resident #2). The findings include: Based on interview and record review the facility failed to provide services by qualified persons in accordance with 1 of 4 residents reviewed in the resident sample (Resident #2). The findings include: The facility failed to implement the plan of care for Resident #2 regarding the utilization of "as needed" Trazadone for resident symptoms of restlessness, wandering and insomnia on 4 occasions during the time period of 12/9/11 to 1/8/12. Per review of the comprehensive care plan dated 12/9/11, titled, Anxiety related to	F 282	All resident care plans were reviewed to ensure appropriate interventions are in place. Policies regarding care planning and documentation were reviewed and updated as necessary. DNS/SDC provided education to staff involved in care planning and documentation. DNS or designee will perform audits of 5 resident care plans per quarter to ensure that updates and documentation are completed as necessary. Results will be reported at QA meetings. DNS to monitor for compliance. <i>F282 POC accepted 2/24/12 Mewman RN/AMCOARW</i>	2/22/12 2/15/12 2/22/12 Ongoing Ongoing

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F 282	Continued From page 17 cognitive deficits, the care plan indicates that Trazadone (medication to help with symptoms of insomnia) is to be given per MD order and utilizing of the PRN (as needed) dose when unable to settle the resident with non pharmacological methods. Per review of the medication administration record of 12/13/11, Resident #2 received a PRN dose of Trazadone 25 mg two times on 12/13, for agitation and insomnia. Review of the nurse's notes showed there was no documented evidence of any non pharmacological interventions used prior to the administration of the Trazadone. Review of the medication administration record dated 12/20/11, 12/23/11 and 1/8/12, Resident #2 received 100 mg of PRN Trazadone for symptoms of wandering and insomnia. Review of the nurse's notes showed there was no documented evidence of any non pharmacological interventions used prior to the administration of the Trazadone. Per interview with the Director of Nursing on 1/23/12 at 11:28 AM, he/she reviewed the nurses notes for 12/13/11, 12/20/11, 12/23/11 and 1/8/12 and confirmed that no documentation was in the medical record regarding any non pharmacological interventions prior to the administration of PRN Trazadone.	F 282			