

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 27, 2013

Ms. Melissa Jackson, Administrator
Vermont Veterans Home
325 North Street
Bennington, VT 05201-5014

Dear Ms. Jackson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on February 26, 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:jl



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

PRINTED: 03/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2013
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NAME OF PROVIDER OR SUPPLIER VERMONT VETERANS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 325 NORTH STREET BENNINGTON, VT 05201
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced on-site investigation of complaints and facility self-reported incidents was conducted by the Division of Licensing and Protection on 2/25/13 and 2/26/13. There were regulatory deficiencies identified.</p> <p>F 223 483.13(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 upon staff interview and record review, the facility failed to ensure that 5 of 10 residents (Residents #6, #7, #8, #9 & #10) in the sample group were free from verbal, physical, and/or mental abuse. Findings include:</p> <p>1. Per record review, the facility failed to prevent the abuse of residents by other residents of the facility.</p> <p>Per record review of the facility's report marked 'Behavior Incident', on 1/22/13 Resident #9 "punched [Resident #6 two times] in the face. [Resident #6] punched [Resident #9] in the chest [two times] and in the face [once]".</p> <p>Per record review of Nursing Notes dated 1/30/13 "this vet's [Resident #9] shirt was pulled by</p>	F 000	<p>The filing of this plan of correction does not constitute an admission of guilt. Vermont Veterans Home ("the Provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements.</p> <p><u>F223 Free From Abuse/Involuntary Seclusion</u></p> <p>Resident #8 has a care plan in place for behaviors. Since the 2/15/13 altercation and subsequent unit change as an intervention this veteran has had no documented behaviors. A "huddle" was conducted by Social Services on 1/30/13, 2/7/13, 2/7/13, 2/15/13 and 3/1/13 along with his MDS review and the care plan was reviewed at that time.</p> <p>Resident #7 has a care plan in place for behaviors. Since the 2/15/13 altercation this veteran has had no documented behaviors. A "huddle" was conducted by Social Services on 1/9/13, 1/22/13, 2/6/13, 2/15/13 and 3/18/13 and the care plan was revised at that time.</p> <p>Resident #8 has had no altercations since the 2/15/13 incident. This veteran's fingers are healed at this time. Social Services reviewed the plan of care on 3/19/13.</p> <p>Resident #9 has a care plan for behaviors in place. This veteran's last documented incident was 2/14/13. No injury occurred during that incident and the veteran was at baseline directly after the event. Social Services revised the care plan on 3/11/13 and conducted a "huddle" on 3/16/13.</p> <p>Resident #10 has a care plan for behaviors in place. This veteran's last documented incident was 2/2/13. A "huddle" was conducted by Social Services on 1/9/13, 2/6/13, 2/22/13.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature] TITLE: [Signature] (X6) DATE: 03/26/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	<p>Continued From page 1</p> <p>another vet [Resident #6]. This vet punched the other vet [two times] in the face".</p> <p>Per record review of Nursing Notes dated 2/2/13 "this veteran [Resident #8] grabbing at right wrist of the other veteran [Resident #10], the other veteran grabbing the left wrist of this veteran. Both veterans attempting to swing out at each other".</p> <p>Per record review of the facility's investigation dated 2/22/13 of an incident on 2/15/13, Resident #6 pushed Resident #7 "into the hallway. [Resident #7] fell onto [Resident #8]...[Resident #8] fell to the floor with [Resident #7] on top of him". Resident #7 "was found to have minor abrasions...[Resident #8] complained of pain in several areas including [h/her] back, chest, and hip." Resident #8 "was diagnosed with 2 dislocated fingers and 1 fractured finger".</p> <p>Per interview on 2/25/13 at 4:30 P.M. the facility's Director of Nursing confirmed that the four incidents within a month, on 1/22/13, 1/30/13, 2/2/13 and 2/15/13 involved resident to resident physical altercations, the incident on 2/15/13 required an emergency room treatment for Resident #8, and that the actions demonstrated by resident[s] during all four incidents, though the residents were cognitively impaired, would be considered 'willful'.</p>	F 223	<p>3/15/13 and 3/16/13 and the care plan was reviewed at that time.</p> <p>All veterans' who have had a veteran to veteran altercation since February 1st has had a "huddle" conducted by Social Services, all findings were documented in the clinical record, and their care plans were reviewed and revised as warranted.</p> <p>An analysis was conducted on incidents and times were determined to place a Hall Monitor Program for increased observation as a result of the analysis.</p> <p>Education will be provided to facility staff beginning on 3/20/13 regarding prevention of veteran to veteran altercations. This education will be ongoing.</p> <p>The Director of Social Services or designee will conduct weekly audits on all veterans who have had veteran to veteran altercations to ensure the care plans is effective in intervening with behaviors.</p> <p>Data from the audits will be brought to the Quality Assurance meeting every other month for 6 months or until the committee determines resolution.</p> <p>The Administrator is ultimately responsible to ensure that veterans are free of abuse.</p> <p>An IDR is being submitted for this deficiency.</p>	
F 225 SS=E	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have</p>	F 225	<p>Compliance Date: March 30, 2013</p> <p><i>Accepted POC 3/26/13 for F223</i> <i>Suzanne J. Emmerson RN</i></p>	

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F 225 Continued From page 2
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).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

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.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to ensure that all alleged violations of abuse, neglect, mistreatment, misappropriation

F 225 F225 Investigate/Report Allegations
Resident #2 is deceased

Resident #3 incident occurred on 11/12/12 and was reported to L&P on 11/13/12 with the conclusion reported on 11/19/12 within the 5 working day requirement. The veteran was evaluated by the physician on 11/13/12 findings were no obvious pulmonary or cardiac issues. This veteran has had no verbalizations of neglect and voices no issues with care.

Residents #6, #9 and #10 incidents were reported to L&P at the request of the surveyor on 3/18/13. These veterans had no negative outcomes as a result of the incidents, had no recollection of the incident and were at baseline directly after the incident. The care plans were revised to reflect their current status.

All veteran to veteran altercations since February 1st were audited and all were reported to L&P on 3/20/13.

The Director of Nurses or designee will call L&P after any veteran to veteran altercation to confer with the department to inquire if the incident must be reported, and will report as directed.

The Administrator or designee will conduct random audits of any veteran to veteran altercation to ensure reporting was conducted as directed.

Data from the audits will be brought to the Quality Assurance meeting every other month for 6 months or until the committee determines resolution.

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F 225	<p>Continued From page 3</p> <p>of property and injuries of unknown origin are thoroughly investigated and reported to other officials in accordance with State law through established procedures for 5 applicable residents (Residents #2, #3, #6, #9, #10) of 15 in the sample group. The findings include:</p> <p>1. The facility failed to have evidence that an alleged incident of abuse against Resident #2 was thoroughly investigated and those results reported within 5 working days of the incident to the State Survey and Certification Agency (DLP). Per the Incident and Accident report dated 09/22/12 at 5 p.m. states "vets [family] reported LNA was rough with [resident] during care, [s/he] stated a pillow was put down the back roughly and reclined [resident's] chair. MD notified on 09/24/12". Per review of the facility event report states "[LPN] reported to DNS on 0645 on 9/23/13 that [family] of Vet reported that [LNA] was rough with [resident] during care on 09/22/12."</p> <p>On 09/24/12 a report was faxed to Adult Protective Services (APS), greater than 24 hours after the incident. A summary report was faxed to DLP on 10/11/12, 19 days after the incident.</p> <p>Per interview on 02/25/13 at 1:26 P.M. the LNA stated "I was told the next day that I had to leave" and that several weeks later was interviewed. "No one asked for a written statement until that time, I guess they made an internal investigation". Per interview on 02/26/12 at 2:56 P.M. the DNS confirmed that staff did not report the incident in a timely manner and the results of the investigation was not reported within 5 working days.</p>	F 225	<p>The Administrator is ultimately responsible to ensure reports to L&P are conducted.</p> <p>Compliance date: March 30, 2013</p> <p><i>POC accepted for F-225 Sharon J. Emmons, RN 3/26/13</i></p>	
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F 225	<p>Continued From page 4</p> <p>2. The facility failed to have evidence that an alleged incident of neglect against Resident #3 was thoroughly investigated and those results reported within 5 working days of the incident to the State Licensing Agency. The Adult Protective Services (APS) was notified on 11/13/12 of an alleged incident of resident neglect on 11/12/12. Per review of the Social Service note of 11/13/12 states that at 2:15 P.M. "[family member] called with concerns will continue to follow up with concerns, talked to nursing and continue to work with [resident] on adjusting to unit". There is no further documentation as to the follow ups, to whom, nor the conversation with nursing. Per review of the facility's incident report, the facility investigation was written on 11/19/12, seven days after the 11/12/12 incident. The State Licensing Agency was told during telephone interview on 11/16/12 that a summary will be faxed. A revised investigation was sent on 12/05/12, however the alleged perpetrator was not interviewed until 12/20/12, nearly 1 month after incident. Per interview on 02/26/13/ at 3:14 p.m. the DNS confirmed that the incident was not reported timely and thoroughly investigated within the 5 day timeframe as evidenced by lack of documentation.</p> <p>3. The facility failed to have evidence that an alleged incident of abuse between Resident #6 and #9 was thoroughly investigated and those results reported within 5 working days of the incident to the State Survey and Certification Agency (DLP). Per record review of the facility's report marked 'Behavior Incident', on 1/22/13 Resident #9 "punched [Resident #6 two times] in the face. [Resident #6] punched [Resident #9] in</p>	F 225		
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F 225	<p>Continued From page 5</p> <p>the chest [two times] and in the face [once]".</p> <p>The facility failed to have evidence that an alleged incident of abuse between Resident #6 and #9 was thoroughly investigated and those results reported within 5 working days of the incident to the State Survey and Certification Agency (DLP). Per record review of Nursing Notes dated 1/30/13 "this vet's [Resident #9] shirt was pulled by another vet [Resident #6]. This vet punched the other vet [two times] in the face".</p> <p>The facility failed to have evidence that an alleged incident of abuse involving Resident #6 and #10 was thoroughly investigated and those results reported within 5 working days of the incident to the State Survey and Certification Agency (DLP). Per record review of Nursing Notes dated 2/2/13 "this veteran [Resident #6] grabbing at right wrist of the other veteran [Resident #10], the other veteran grabbing the left wrist of this veteran. Both veterans attempting to swing out at each other".</p> <p>Per interview on 2/25/13 at 4:30 P.M. the facility's Director of Nursing confirmed that the three incidents, on 1/22/13, 1/30/13, and 2/2/13 involved resident to resident physical altercations, and that the actions demonstrated by resident[s] during all three incidents, though the residents were cognitively impaired, would be considered 'willful'. The DNS stated that the 3 incidents of abuse, occurring on 1/22/13, 1/30/13, and 2/2/13, were not reported to the state agency as required by federal and state regulations.</p>	F 225		
F 241	483 15(a) DIGNITY AND RESPECT OF SS=D INDIVIDUALITY	F 241		

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F 241 Continued From page 6

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:

The facility failed to care for 1 applicable resident in a manner maintains or enhances Resident #5's dignity and respect in full recognition of his or her individuality. Findings include:

- Per observation on 02/25/13 at 10:45 A.M. Resident #5, who has dementia, stated to the nurse surveyor in the TV room, "I would like something to eat, I'm hungry, I didn't have breakfast". The nurse surveyor told staff that Resident #5 is hungry and then heard the staff say to the resident that "lunch will be soon". Approximately 15 minutes later the resident came walking out of T.V. room saying s/he was hungry, another staff person spoke into the right ear saying "you'll be having food soon, soup will be up about 11:30, soon" and walked away. Neither staff offered drink or food.

At this time (11:00 A.M.) the LPN, stated to nurse surveyor "[s/he] eats all the time, stays up at night and complains of stomach aches all the time, [s/he] sleeps in, so [s/he] eats late and then forgets". Nurse surveyor then asked for the care plan. The Resident's care plan for Nutrition dated 01/31/12 states "at risk related to dementia, depression, and hyponatremia, tends to stay up late and eats lots of the time, frequently sleeps late receives a therapeutic diet r/t [related to] serum sodium levels that drops, lactose

F 241 F 241 Dignity and Respect of Individuality

Unit staff that were on duty at 10:45 am on 2/25/13, have all had 1:1 education provided same day on providing snacks as veterans request and are care planned for.

In addition, education was provided to nursing and LNA staff beginning on 2/25/13 regarding honoring request for food/fluids and per the plan of care.

CCCs or designee will conduct random weekly audits to ensure that requests are being honored for food/fluids.

Data from the audits will be brought to the Quality Assurance meeting every other month for 6 months or until the committee determines resolution.

The Administrator is ultimately responsible to ensure that dignity is being maintained.

Compliance date: March 30, 2013

*POC accepted for F-241
Susan L. Emmaro PA
3/26/13*

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F 241	Continued From page 7 intolerant, feeds self, makes needs known, regular texture, shall accept food/fluids of choice." Per the care plan, interventions include; "hydration protocol, offer meal alternative and give snack/meals when up at night, assess food likes/dislikes...encourage dining in social setting." At 11:14 A.M. in the dining/activity area, the activity person was observed giving Resident #5 some juice and stated to the nurse surveyor "[s/he] can have a snack anytime." Per interview at 11:15 A.M. the dietician stated "[s/he] can eat anytime [s/he] likes", and was given a sandwich. Per interview at that time the Unit Manager stated that the resident likes protein sandwiches, eggs, that the spouse works in the kitchen and will make sandwiches but will generally not finish the whole sandwich. The Unit Manager confirmed and stated that "staff should know better [in providing snacks to the resident when the resident asks]" and staff did not assist the resident in a timely manner.	F 241	F250 Provision of Medically Related Social Services. Resident #1 has a carefully crafted care plan in place for his behaviors and directing the staff when negative verbalizations occur. This alert and oriented veteran is care planned for rejection of care. This veteran was reviewed by the physician and had the care plan reviewed and revised to alert the physician weekly of refusals for care. In addition, it is documented that the physician will review rejections of care with the veteran with routine visits and will document the risk vs. benefit of the rejection at that time. All alert and oriented veterans who verbalize rejection of care and display behaviors were audited to ensure that documentation for the behaviors is present, that risk vs. benefit of the rejection of care is present in the physician notes and all care plans will be revised to ensure interventions are placed to reduce the reoccurrence of the behaviors.		
F 250 SS=D	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	F 250	The Director of Social Services or designee will conduct weekly random audits of veterans' behaviors to ensure that documentation for the behaviors is present, that risk vs. benefit of the rejection of care is present in the physician notes and all care plans will be revised to ensure interventions are placed to reduce the reoccurrence of the behaviors. Education to Social Service staff will be conducted on 3/25/13 regarding documentation for the behaviors, risk vs. benefit of the rejection of care is present in the physician notes and that all care plans are reflective of the behavior and interventions are placed to reduce the reoccurrence of the behaviors.		

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F 250	<p>Continued From page 8</p> <p>well-being of one resident identified (Resident #1). The findings include:</p> <p>1. Per medical record review, Resident #1 was admitted to the facility on 6/13/11. Resident #1 had diagnosis that included; cellulitis, lymphedema, chronic kidney disease, diabetes, and urinary incontinence.</p> <p>Per review of the Comprehensive Assessment (MDS) dated 1/14/13, is independent in daily decision making. Resident #1 has no short or long term memory issues, the MDS indicates that Resident #1 is short tempered and easily annoyed during the assessment period 7-11 days and rejects care 4-6 days of the assessment period.</p> <p>Per review of the Nurses notes and physician progress notes on 2/25 and 2/26, there were numerous instances documented of Resident #1 being verbally abusive and degrading, physically abusive, throwing things at staff, manipulative with care and treatments, and non-compliance and refusals of daily care and treatments.</p> <p>Per interview with primary Licensed Nursing Assistant (LNA) on 2/25/13 at 1:58 PM, he/she indicated that Resident #1 frequently refuses care. The LNA indicated that Resident #1 dictates his/her care and speaks down to staff. The LNA indicated that staff "are afraid of [Resident #1]...so no one makes waves and just do what [he/she] wants". The LNA indicated that it is difficult to provide appropriate care to Resident #1 because of his/her refusals of care.</p> <p>Per review of the Comprehensive Care Plan</p>	F 250	<p>Data from the audits will be brought to the Quality Assurance meeting every other month for 6 months or until the committee determines resolution.</p> <p>The Administrator is ultimately responsible to ensure that medically related social services is provided.</p> <p>An IDR is being submitted for this deficiency.</p> <p>Compliance date: March 30, 2013</p> <p><i>Poc accepted F-250 Susan J. Emmons, RN 3/25/13</i></p>		

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F 250 Continued From page 9
updated on 1/28 and 2/25/13 and titled "Mood and Behavior", the care plan indicates that Resident #1 is resistive to medical treatment and evaluation and Resident#1 declines care and treatments.

Per interview with the UM on 2/26/13, he/she confirmed that the nurses progress notes indicate that Resident #1 is verbally abusive, physically abusive at times, and displays manipulative and controlling behaviors and refuses health care frequently. The UM confirmed that these behaviors are displayed on a day to day basis some behaviors are even seen shift to shift and interfere with the care being provided to Resident #1. The UM reviewed the comprehensive care plan and confirmed that there was no care plan that addresses the specific behaviors displayed by Resident #1 of verbal, physical abuse, manipulative and controlling behaviors. Also confirmed that there were no goals and/or interventions to help Resident #1 minimize these behaviors and prevent reoccurrence. The UM confirmed that from 1/22/13 to 2/25/13, Resident #1 had refused medical treatments and care and that the interventions listed in the care plan of re-education of resident, reapproach, and encouragement of resident were not effective because they were not being implemented.

Per interview on 2/26/13 with the Director of Nursing, he/she confirmed that Resident #1 is verbally abusive, physically abusive at times, and displays manipulative and controlling behaviors and refuses health care frequently. The DNS confirmed that these behaviors are displayed on a day to day basis some behaviors are even seen shift to shift and interfere with the care being

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F 250	Continued From page 10 provided to Resident #1. In interview the DNS indicated that the interdisciplinary team had met on several occasions and developed a plan with the physician on how to deal with Resident #1's behaviors. After review of the medical record and care plan the DNS was unable to provide documentation that the interdisciplinary team had created a plan to intervene and assist Resident #1 with his/her specific behaviors of verbal/physical abuse, manipulation and controlling behavior with health care and was unable to provide documentation on how the facility was preventing reoccurrence of these behaviors. Per interview with the Social Service Worker on 2/26/13 at 12:49 PM, he/she confirmed that Resident #1 displays behaviors that include the resident being verbally and physically abusive, manipulation of medical care and displays controlling behaviors. The SSW confirmed that these behaviors make it difficult to care for Resident #1. The SSW reviewed the SS progress notes and confirmed that there was no documentation that indicated that Resident #1 had behaviors that include being verbally and physically abusive, manipulative and controlling with care and refusals of care and there was no documentation in the progress notes that indicated how these behaviors were addressed to help minimize and prevent reoccurrence. The SSW reviewed the "Mood and Behavior" care plan and confirmed that from 1/28/13 to 2/25/13 there were no resident specific goals or interventions to meet the resident's needs regarding verbally and physically abusive behaviors, manipulation and controlling behaviors with care, and that there were no interventions	F 250			

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F 250 Continued From page 11 that indicated how these behaviors would be reduced and/or prevent reoccurrence.

F 282 SS=E 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 services by a qualified persons in accordance with three of ten residents' written care plan. (Resident #1, #2 & #4) The findings include:

1. Per medical record review, Resident #1 was admitted to the facility on 6/13/11. Resident #1 had diagnosis that included; cellulitis, lymphedema, chronic kidney disease, diabetes, and urinary incontinence.

Per review of the Comprehensive Assessment (MDS) dated 1/14/13, is independent in daily decision making. Resident #1 has no short or long term memory issues, the MDS indicates that Resident #1 is short tempered and easily annoyed during the assessment period 7-11 days and rejects care 4-6 days of the assessment period.

Per review of the medical record on 2/25/13, Resident #1 refused care and treatments on 2/4 8:50 AM (vital signs), 2/4/13 at 9:45 PM (vital signs), 2/5 at midnight (vital signs), 2/5 at 10:35

F 250 F282 Services by Qualified Staff per care plan

F 282 Resident #1 rejection of care and education is documented in the physician notes since admission. This veteran's MAR has been reformatted with spaces available for nursing staff to sign off on for rejection of the tests and that education was provided at the time of the rejection.

Resident #2 is diseased.

Resident #4 has behavior monitoring in place for behaviors of combativeness. There have been no episodes of combativeness or altercations since 11/17/13. The care plan in place at this time is successful in reducing and preventing behaviors.

All veterans with rejection of care, those who are hard of hearing and with behaviors involving veteran to veteran altercations will be audited to ensure that care plans are implemented.

Education to nursing and LNA staff will begin on 3/20/13 and will be ongoing.

ADNS or designee will conduct random weekly audits of residents with rejection of care, those who are hard of hearing and with behaviors involving veteran to veteran altercations will be audited to ensure that care plans are implemented.

Data from the audits will be brought to the Quality Assurance meeting every other month for 6 months or until the committee determines resolution.

The Director of Nurses is ultimately responsible to ensure that the plan of care is implemented.

POC accepted F-282
3/26/13
Jean J. Emmert RN

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F 282	<p>Continued From page 12</p> <p>AM (vital signs), 2/7/13 at 9:30 PM (vital signs), 2/8/at 2:30 AM (vitals signs and observation of abdomen), 2/8/13 at 9:45 PM (vital signs), 2/9/at 1:00 PM (blood pressure), 2/9/13 9:45 PM (blood pressure), 2/11/13 at 3:30 AM (vital signs) 2/12 at 12:30 PM (vital signs), 2/13 at 2:00 AM (vital signs), 2/13 at 5:45 AM (blood work), 2/13 at 10:30 AM (vital signs), 2/21 at 3:45 AM (personal care on rounds, vital signs), 2/21 at 1:00 PM (chemsticks and insulin), 2/23 at 9:30 PM (chemstick and insulin), 2/24 at 1:30 AM (vital signs), 2/24 at 10:00 PM (chemstick and insulin), 2/25/at 3:00 Am (vital signs), 2/25 at 5:50 AM (bloodwork), and 2/25 at 1:30 PM (chemsticks).</p> <p>Per review of the Comprehensive Care plan initiated on 1/28/13 and titled "Mood and Behavior" indicates that Resident #1 is "resistive to medical treatment and evaluation including blood tests." The care plan also indicates that Resident #1 will decline care and treatment at times. The care plan interventions indicate that the facility will encourage compliance with ordered medical tests and that staff will "review with [Resident #1] reason and need for tests and explain risk of refusing".</p> <p>Per review of the nurses notes there was no evidence that Resident #1 was encouraged to comply with medical orders on these dates, there was no evidence in the nurses notes that Resident #1 was educated on need for the tests and educated on the risks of refusing per the care plan.</p> <p>Per interview with the UM on 2/26/13, he/she reviewed the nurses progress notes and confirmed that Resident #1 had refused care.</p>	F 282	<p>An IDR is being submitted for this deficiency.</p> <p>Compliance date: March 30, 2013</p>		

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F 282 Continued From page 13 including vital signs, blood work and diabetic fingersticks and insulin administration from 1/22-2/25/13. The UM confirmed on 2/26/13 that there was no documentation that Resident #1 was encouraged to comply with ordered medical tests or educated on the need for and the risks of refusing tests and care on 2/4, 2/5, 2/7, 2/8, 2/9, 2/11, 2/12, 2/13, 2/21, 2/23, 2/24 or 2/25 as per the care plan.

Per review of the Comprehensive Care Plan initiated on 8/2/12 and reviewed and revised on 1/22/13 and 2/20/13, and titled "At risk for Hyper/Hypoglycemia", the care plan indicates that Resident #1 often "refuses chem sticks". The care plan indicates that chem sticks are to be done per physician order and Re-Approach for refusals. The care plan updated on 2/20/13 also indicates that Resident #1 is to have Accu-checks three times a day with coverage with meals.

Per review of the nurses notes and medication administration record, there was no evidence that Resident #1 was re-approached with refusals of tests and treatments, and there was no evidence that Resident #1 was re-educated at the risks of refusing tests and treatments.

Per interview with the UM on 2/26/13, he/she reviewed the medical record and confirmed that from 1/22/13 through 2/25/13 there was no documentation that indicated that Resident #1 was re-approached by staff after refusing chem sticks and/or insulin coverage. The UM also confirmed that there was no documentation that Resident #1 was educated on the risks of refusing as per the care plan.

F 282

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F 282	Continued From page 14 2. Per record review and staff interviews, Resident #2 was care planned for Cognition Problems related to dementia. Staff are directed to approach and speak in a calm manner, make eye contact, be patient and explain procedures before doing them, and ask yes/no questions. The Care Plan for Communication directs staff to speak slowly and clearly, make eye contact, approach from the front, explain all interventions, anticipate needs, observe non-verbal clues. The ADL function/impaired care plan states, extensive assist, can be resistive, reapproach after refusal, scoot chair for locomotion and may startle during approach to give care. Per review of an incident report, the family of Resident #2 stated that staff treated this resident roughly by shoving a pillow down the back and roughly moving the chair. This caused the resident to become startled making both family and resident upset. Per interview on 02/25/13 at 1:36 P.M. the LNA staff stated that around the change of shift the family said the resident was uncomfortable and asked if the resident was uncomfortable which s/he replied yes. "[S/he] was in a broda-chair at 95 degree angle, which didn't have a pillow, so I did place one behind the back and I said I will be reclining you but [s/he] was hard of hearing and when I moved [her/him], [resident] startled. The LNA stated that when adjusting the chair, the back as well as the legs move simultaneously. The LNA confirmed at this time the s/he was behind the chair. The DNS confirmed that staff did not follow the care plan as written for this resident by speaking slowly and directly in front.	F 282			
	3. Per record review of Resident #4's care plan				

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F 282	<p>Continued From page 15</p> <p>dated 7/20/12 for Behavior and Mood related to Alzheimer's dementia, depression, lose of family/home life, behaviors and becoming agitated and confused, the care plan directs staff to: monitor mood and behavior, provide 1-1 time, conversations in quiet area, maximize [resident's] strengths, loves westerns John Wayne/John Denver, loves chocolate, reassure that [spouse] will return.</p> <p>Per review of the nursing notes, social service notes and physician progress notes from July 2012 through February the resident had incidents of exit seeking, insomnia, refusing care, resident to resident altercations and aggression towards staff. The resident was also on an anti-psychotic medication. The Behavior Monitoring Flow Sheets are noted for exit seeking, insomnia and refusing care. However, there is no Behavior Monitoring Flow Sheet for agitation or combativeness until mid December 2012.</p> <p>Per a physician progress note during the week of 12/17/12, the Nurse Practitioner's Progress note states "per nursing report of increased behavior since lowering risperidone; no documentation to support, check behavior monitor and re-educate". Per a nursing note of 12/18/12 states "provider ordered behavior monitor x 3 days, then re-evaluate".</p> <p>Per interview on 02/25/13 at 2:23 P.M. the staff nurse stated, "I would expect that we use the Behavior Flow Sheets especially for someone who has known aggression and is taking medication for it, we usually do." The unit manager at that time confirmed that there was no behavior flow sheet to monitor for aggression and</p>	F 282		

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F 282 Continued From page 16
 combativeness prior to December 2012.

F 282