

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

February 12, 2013

Ms. Jeanne Schmelzenbach, Administrator
Loretto Home
59 Meadow Street
Rutland, VT 05701-3994

Provider #: 0138

Dear Ms. Schmelzenbach:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **December 4, 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:ne

Enclosure



PRINTED: 12/18/2012
FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/04/2012
NAME OF PROVIDER OR SUPPLIER LORETTO HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 59 MEADOW STREET RUTLAND, VT 05701		
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R136	Continued From page 1 that Resident #1 was verbally or physically aggressive with staff and/or other residents. Per the Nurses notes it was noted that Resident #1 fell at the facility on 6/16, 7/7, 7/9, 10/3 and 10/14 and 10/19/12. The Nurses notes indicated that on 7/7/12 that Resident #1 was noted to be hanging off bed, having trouble walking, was stumbling and unsafe to walk without assistance. The notes indicate that resident was sent to emergency room and the physician indicated that resident was "fine" and believes that the resident's issues are a result of his/her progressing dementia. The physician indicated to staff that resident should be a two person assist and utilize a wheelchair due to Resident #1's unsteady gait. The nursing note indicates that the facility needs to start arrangements for nursing home placement. Per review of the Nurse's notes, Resident #1 was noted to be wandering in and out of other residents rooms on 6/2/12, 7/6/, 7/22, 10/1, 10/3, and 10/20. Per interview with the Charge Nurse on 12/4/12, he/she reviewed the assessment dated 1/13/12 and updated on 4/24/12 and confirmed that Resident #1 had physical and mental changes in condition and that the assessment did not accurately identify the current physical and mental status of Resident #1.	R136	A PT referral was made 10/19/2012 and a side rail was installed. Due to resident's dementia, she was deemed to be unsafe to use a cane or a walker. Effective 1/28/13, Loretto will ensure that a Change of Condition Assessment is completed according to state regulations. The Nursing QI committee will review the charts of Residents with Changes of Condition quarterly to ensure that new assessments with updated care plans are in these Resident's Nursing Charts.	
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any	R206		

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R206	Continued From page 2 case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that any case of suspected abuse, neglect or exploitation be reported within 48 hours of learning of the suspected, reported or alleged abuse. The findings include: 1. Per review of the facility internal investigation, on 7/22/12 there was a resident to resident altercation that occurred between two residents (Resident #1 and Resident #2) of the 6 residents reviewed. Per the facility incident report and the nurse's notes on 7/22/12, Resident #1 entered the room of Resident #2 and Resident #2 grabbed Resident #1 by the wrists in an attempt to remove Resident #1 from the room. Resident #1 pushed Resident #2 causing Resident #2 to fall backward into the closet and sustaining a bruise and a skin tear. Per review of the facility investigation the incident occurred on 7/22/12 and the fax that the facility sent to Adult Protective Services (APS) indicates that APS was notified of the incident on 7/30/12, eight days after the incident occurred.. Per interview with the Director of Nursing Services (DNS) on 12/4/12 at , he/she indicated that he/she had not notified APS of the incident within 48 hours because he/she was still investigating the incident from 7/22/12 and that it	R206	<u>R206 Resident Care and Home Services</u> <u>5.18.a:</u> The Administrator and the DON have reviewed the regulations and understand fully that <u>any</u> staff member can report an incident of suspected, reported or alleged incidents of abuse, neglect or exploitation to APS not just the DON or Administrator. Effective 12/7/2012 the Loretto Home will report suspected or reported incidents of abuse, neglect or exploitation within 48 hours followed by our own investigation. An APS Reporting Procedure has been written and is placed in the on-call triage nurse book (See Attachment #2). The process has already been reviewed by all charge PCA's and the process for reporting to APS is being in-serviced with the rest of our nursing staff on 1/15/2013. Effective 1/28/13, each time a Resident on Resident incident occurs, the DON, House Nurse or Administrator will complete a chart review to ensure that the Loretto Home reports every appropriate case of suspected abuse, neglect, or exploitation to the Adult Protective Services within 48 hours of learning of the incident.	

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R206	<p>Continued From page 3</p> <p>had occurred over a weekend. The DNS indicated that he/she was unaware that a report of suspected abuse had to be reported to APS within 48 hours even if the facility investigation was not completed.</p> <p>2. Per review of the facility internal investigation dated 9/30/12, there was a resident to resident altercation that occurred between two residents (Resident #5 and Resident #6). Per the facility incident report, Resident #5 entered the facility elevator and coughed on Resident #6. Resident #6 turned around and slapped Resident #5 on the right side of the face.</p> <p>Per review of the facility investigation the incident occurred on 9/30/12 and per the facility fax that the facility sent to Adult Protective Services (APS) indicates that APS was notified of the incident on 10/4/12, four days after in incident occurred.</p> <p>Per interview with the DNS on 12/4/12, he/she indicated that he/she was unaware that a report of suspected abuse had to be reported to APS within 48 hours even if the facility investigation was not completed.</p>	R206		
R207 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.18 Reporting of Abuse, Neglect or Exploitation</p> <p>5.18.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected</p>	R207		

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R207	<p>Continued From page 4</p> <p>incident to Adult Protective Services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that an incident of suspected abuse involving 2 facility residents of the 6 reviewed (Resident #3 and Resident #4) was investigated and reported to Adult Protective Services (APS). The findings include:</p> <p>1. Per review of the medical record of Resident #3, the nurses notes indicated on 6/22/12, Resident #3 grabbed another residents arm while entering the dining area. Per review of the facility incident report, the report indicates that Resident #3 hit Resident #4 in the left arm and was "digging" Resident #4's left arm in the dining room and that Resident #4 was very upset about the incident.</p> <p>Per interview with the Director of Nursing (DNS) on 12/4/12, he/she indicated he/she remembered the incident but was unable to provide a facility investigation regarding the incident on 6/23/12. The DNS was also unable to provide documentation that the incident on 6/23/12 between Resident #3 and Resident #4 had been reported to APS.</p> <p>Per e-mail with APS on 12/4/12, the e-mail indicated that APS had no record of a report of the 6/23/12 incident between Resident #3 and Resident #4 reported to APS by facility staff.</p>	R207	<p><u>R207 Resident Care and Home Services</u></p> <p><u>5.18.b:</u></p> <p>While the timeliness of the reporting was delinquent, we have evidence of a fax sent to Tricia Cummings on 7/16/12 and refaxed to Marianne Culihan on 12/13/12 which was submitted to DIAL. Effective 12/10/12 All Incident reports are now kept in a three ring binder for easy access.</p> <p>We believe that the incident reported 6/30/12 by Janiel Teichman was indeed the 6/23/12 incident which has supporting documentation in resident #3's chart. Nevertheless, we will comply as stated previously to the 48 hour reporting time frame followed by an internal investigation by our DON and nursing staff.</p> <p>Effective 1/28/13, each time a Resident on Resident incident occurs, the DON, House Nurse or Administrator will complete a chart review to ensure that the Loretto Home reports every appropriate case of suspected abuse, neglect, or exploitation to the Adult Protective Services within 48 hours of learning of the incident.</p>
R208 SS=A	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.18 Reporting of Abuse, Neglect or Exploitation</p>	R208	

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R208	<p>Continued From page 5</p> <p>5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that all resident to resident incidents for 2 residents of 6 identified (Resident #6 and #5) are recorded in the resident's medical record. The findings include.</p> <p>1. Per review of the facility internal investigation dated 9/30/12, the report indicates that Resident #5 and Resident #6 were in the elevator to go upstairs. Resident #5 coughed on Resident #6, Resident #6 turned around and slapped Resident #5 on the right side of the face.</p> <p>Per review of the medical record for Resident #5 there was no documentation in the medical record indicating that Resident #5 had been slapped by Resident #6 in the elevator on 9/30/12. Per review of the medical record of Resident #6, there was no documentation indicating that Resident #6 had slapped Resident #5 in the elevator on 9/30/12.</p> <p>Per interview with the Charge Nurse and DNS on 12/3/12, they confirmed that both Resident #5 and Resident #6 had medical diagnoses that included dementia and that both Resident #5 and Resident #6 had incidences of being aggressive</p>	R208	<p>R208 Resident Care and Home Services</p> <p>5.18.c: An in-service is schedule for 1/15/13, the DON is reviewing proper documentation procedures and charting that must be communicated in the nurse's notes. The aides are being instructed that all resident-to-resident incidents, even minor ones must be recorded in the resident's record. Staff will be instructed to record incident in <u>both</u> the aggressor's chart and the victim's chart. Effective 1/28/13, each time a Resident on Resident incident occurs, the DON, House Nurse or Administrator will complete a chart review to ensure that the Loretto Home records the incident in the resident's record and that Families or legal representatives are notified, and a new plan is developed to deal with the behaviors.</p>	

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R208	Continued From page 6 towards other residents. The Charge Nurse and DNS confirmed that on 9/30/12 Resident #5 was slapped in the elevator by Resident #6.	R208		
R224 SS=E	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that 6 residents of 6 identified (Resident #1, #2, #3 #4, #5, and #6) were free from physical abuse. The findings include: 1. Per review of the facility report dated 6/26/12, Resident # 3 slapped Resident #6 on the arm while the residents were on the elevator going to the dining room . Resident #6 then hit Resident #3 in return. The report indicates that the residents were separated. Per interview with the Charge Nurse and Director of Nursing (DNS) on 12/3/12, they confirmed that there was a resident to resident altercation between Resident #3 and Resident #6, the Charge Nurse and DNS on 12/3/12, confirmed that both Resident #3 and Resident #6 had medical diagnosis that included dementia and that both Resident #3 and Resident #6 had incidences of being aggressive towards other residents. The Charge Nurse and DNS confirmed that both residents (#3 and #6) were in the elevator going to the dining room and	R224	224 Residents' Rights 6.12 Loretto Staff is actively exploring social service resources. A meeting was held on 1/9/13 at Loretto Home with the RRMC Social Work Department Manager and a Discharge Planning representative to investigate how to best utilize resources in our community since we are finding behavioral placements very difficult. Furthermore, we are reaching out to placement options beyond our county and our state. We will continue to educate ourselves and network with other facilities in an effort to more successfully transition residents out of our facility when they are no longer appropriate for our level of care but are not being accepted readily. At Vermont Catholic Charities we have respect for resident's rights and each individual. We believe that our residents have the right to be free of abuse. To this end the following interventions have been implemented since July of 2012:	

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R224	<p>Continued From page 7</p> <p>Resident #3 slapped Resident #6 on the arm and Resident #6 hit Resident #3 in return.</p> <p>2. Per review of the facility internal investigation dated 7/22/12, the report indicates that Resident #1 entered the room of Resident #2, Resident #2 grabbed Resident #1 by the wrist in an attempt to remove Resident #1 from the room. Resident #1 pushed Resident #2 causing Resident #2 to fall backwards into a closet and sustained a bruise on the right calf.</p> <p>Per review of the nurses notes in the medical record of Resident #1 the notes indicated that Resident #1 had an altercation with another resident, the aide heard yelling and screaming and went to the room to find Resident #1 had wandered into the room of Resident #2 and Resident #2 indicated that Resident #1 pushed him/her. Review of the nurse's notes in the medical record of Resident #2 indicated that on 7/22/12 Resident #2 was seen by staff as they entered the bedroom of Resident #2, that Resident #2 was holding the hands of Resident #1 and Resident #2 verbalized that he/she was pushed into the closet by Resident #1.</p> <p>Per interview with the Charge Nurse and Director of Nursing (DNS) on 12/3/12, they confirmed that both Resident #1 and Resident #2 had medical diagnosis that included dementia and that both Resident #1 and Resident #2 had incidences of being aggressive towards other residents. The Charge Nurse and DNS confirmed that there was a resident to resident altercation between Resident #1 and Resident #2 on 7/22/12 and that Resident #1 wandered into the room of Resident #2 and when Resident #2 grabbed the hands of Resident #1, Resident #1 pushed Resident #2 into the closet and Resident #2</p>	R224	<p>July: Velcro "STOP signs" were made and attached to specific doorways in an effort to keep residents from wandering into one another's rooms.</p> <p>July: Increased staffing to 1.5 FTE for morning and evening shift</p> <p>July: In-service to staff showing bodily insertion/physical positioning to minimize behaviors</p> <p>August: In-service provided by PACE where they had skilled staff come to Special Care unit to train staff on effective communication and approach strategies with dementia residents</p> <p>September: DON started to attend PACE resident review/ care planning meetings</p> <p>September: Divided up residents on elevator transports to decrease behaviors</p> <p>September: Code 33 established</p> <p>October: House nurse began attending PACE planning meetings monthly.</p>	
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R224	Continued From page 8 sustained a bruise to the right calf. 3. Per review of the facility internal investigation dated 9/30/12, the report indicates that Resident #5 and Resident #6 were in the elevator to go upstairs. Resident #5 coughed on Resident #6, Resident #6 turned around and slapped Resident #5 on the right side of the face. Per review of the medical record for Resident #5 there was no documentation in the medical record indicating that Resident #5 had been slapped by Resident #6 in the elevator on 9/30/12. Per review of the medical record of Resident #6, there was no documentation indicating that Resident #6 had slapped Resident #5 in the elevator on 9/30/12. Per interview with the Charge Nurse and DNS on 12/3/12, they confirmed that both Resident #5 and Resident #6 had medical diagnosis that included dementia and that both Resident #5 and Resident #6 had incidences of being aggressive towards other residents. The Charge Nurse and DNS confirmed that on 9/30/12 Resident #5 was slapped in the elevator by Resident #6 after Resident #5 coughed on Resident #6. 4. Per review of the facility internal investigation dated 7/10/12, the report indicates that Resident #1 wandered into the room of Resident #2, Resident #2 became angry at Resident #1 and pushed Resident #1 out of the bedroom and in anger toward Resident #1, Resident #2 bent the fingers of Resident #1 backwards. Per review of the medical record of Resident #1 indicates that on 7/6/12 Resident #1 wandered into the room of another resident and the other resident got mad and shoved Resident #1 out of	R224	October: Increased activities for Special Care Unit residents <ul style="list-style-type: none"> • Providing more activities appropriate for dementia population • Providing one-to-one support of residents when an activity that interests them is occurring • Expanding inventory of activity related supplies for Special Care Unit residents. October: Reviewed staffing and implemented changes to ensure adequate staffing during peak activity periods. December: Painted Special Care Unit a more neutral color December: Initiated overlapping of shifts to decrease behaviors at change of shift. January: Activities Directors have scheduled a meeting with peer Activities Directors in the community to explore activities to support our Special Care Unit residents. January: New activities resources purchased and a meeting with other Activities Director scheduled for creative problem solving	

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R224	Continued From page 9 the room. Per review of the medical record of Resident #2, he/she was mad at another resident for going into the room of Resident #2 and that Resident #2 pushed Resident #1 out and started bending Resident #1's fingers back before it was stopped by the aide. Per interview with the Charge Nurse and DNS on 12/3/12, they confirmed that both Resident #1 and Resident #2 had medical diagnosis that included dementia and that both Resident #1 and Resident #2 had incidences of being aggressive towards other residents. The Charge Nurse and DNS confirmed that on 7/6/12 Resident #1 wandered into the room of Resident #2, Resident #2 became angry at Resident #1 and pushed Resident #1 out of the bedroom and in anger toward Resident #1, Resident #2 bent the fingers of Resident #1 backwards. 5. Per review of the facility internal investigation dated 10/6/12, the report indicates that Resident #5 was in the dining room sitting at a table next to Resident #2. Resident #5 was moaning and Resident #2 became agitated told Resident #5 to stop. Resident #5 did not stop and Resident #2 slapped Resident #5 on the hand. Resident #5 than pointed at Resident #2 and Resident #2 slapped Resident #5 again on the right arm. Resident #5 than hit Resident #2 on the back of Resident #2's arm. Per review of the medical record of Resident #2, the nurse's notes dated 10/6/12 indicates that Resident #2 got mad at another resident for moaning than hit the resident on the hand and on the arm. Review of the medical record indicates that Resident #5 was sitting in the dining room at the dining room table moaning and another resident asked Resident #5 to stop and got	R224	January: We have initiated the practice of identifying residents with challenging behaviors, and have completed chart reviews with associated time-lines, followed by family planning meetings. Our goal is to identify residents who have displayed or are likely to display behaviors that would potentially compromise fellow residents. Status of Six identified residents: #1 Chart review and time-line completed on 12/24/12. Administrator had met with family members informally in December and DON, House nurse and Administrator are planning a formal meeting later this month. #2 A Chart review and time-line completed on 12/24/12. On 1/6/13 she became a full admit at Rutland Hospital where she is at this time. Administrator met with residents son on 1/7/13 to discuss discharge from Loretto Home. Family is currently working with social services at RRMCC. #3 Discharged from our facility in June of 2012 #6 1 Chart review and time-line completed on 12/24/12. Family meeting scheduled for 1-10-13	

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NAME OF PROVIDER OR SUPPLIER LORETTO HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 59 MEADOW STREET RUTLAND, VT 05701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R224	Continued From page 10 agitated by Resident #5 and hit Resident #5 on the arm. The medical record indicates that than Resident #5 pointed at Resident #2 and Resident #2 hit Resident #5 again on the arm. The medical record indicates that than Resident #5 than hit Resident #2 on the arm. 6. Per review of the facility internal investigation dated 10/10/12, the report indicates that Resident #1 was "verbally fighting" with Resident #6 while on the elevator. The report indicates that when Resident #1 exited the elevator he/she struck Resident #6 on the right side of his/her face. Per review of the medical record of Resident #1, it indicates that on 10/8/12 Resident #1 was fighting with another resident in the elevator on the way to supper. Resident #1 slapped Resident #6 across the right side of the face. Per review of the medical record for Resident #6 the medical record indicated that on 10/8/12 Resident #6 was going to the dining room on the elevator with another resident and an aide. Resident #6 had a fight with another resident, and Resident #1 slapped Resident #6 across the right side of the face. Per interview with the Charge Nurse and DNS on 12/3/12, they confirmed that both Resident #1 and Resident #2 had medical diagnosis that included dementia and that both Resident #1 and Resident #2 had incidences of being aggressive towards other residents. The Charge Nurse and DNS confirmed that on 10/8/12 Resident #1 was fighting with another resident in the elevator on the way to supper and Resident #1 slapped Resident #6 across the right side of the face.	R224	Effective 1/28/13, residents with two Resident on Resident incidents will trigger a chart review with an associated timeline, a Change of Condition Assessment, and updated Plan of Care. If behaviors cannot be corrected by staff interventions an alternative placement search will be initiated with a 30 day notice when necessary. These resident charts will be reviewed quarterly by the Nursing QI committee. <i>R136, R206, R207, R208, R224 Plans of Correction accepted 2/6/13 M. Cullivan RN / AMC</i>	