VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

July 5, 2023

Ms. Heather Filonow, Administrator
Wake Robin-Linden Nursing Home
200 Wake Robin Drive
Shelburne, VT 05482-7569

Dear Ms. Filonow:

Enclosed is a copy of your acceptable plans of correction for the investigation survey conducted on **June 16, 2023.** 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

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475056	A. BUILDING: _____ B. WING _____	C 06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKE ROBIN-LINDEN NURSING HOME	200 WAKE ROBIN DRIVE SHELBURNE, VT 05482

(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
S 000	Initial comments The Division of Licensing and Protection conducted an unannounced onsite investigation of a facility reported incident from 6/6/2023 through 6/16/2023. The following violations of the Vermont Licensing and Operating Rules for Nursing Homes were identified.	S 000		
S270 SS=G	4.3 (a-d) QUALITY OF LIFE - SELF DETERMINATION 4.3 The resident has the right to: a. choose activities, schedules, and health care consistent with his or her interests, assessments and plans of care; b. interact with members of the community both inside and outside the facility; c. make choices about aspects of his or her life in the facility that are significant to the resident; d. retain and use his or her personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and policy review, the facility failed to ensure residents have the right to make choices concerning their care related to activities of daily living for 1 applicable resident (Resident #1). This failure resulted in extensive bruising, physical pain, and emotional distress for Resident #1. Findings include: Record review reveals that Resident #1 was admitted to the facility on 6/14/2019 and has diagnoses that include: dementia, essential thrombocythemia, anxiety disorder, and anemia. Resident #1's Minimum Data Set (MDS; a	S270	S 270 Resident #1 is ensured the right to make choices concerning their care related to activities of daily living. All residents have the potential to be affected by the same deficient practice. All residents are ensured the right to self-determination. Staff will be educated on a resident's right to self-determination in accordance with State Regulation 4.3 (a-d) Quality of Life – Self Determination to ensure the deficient practice does not recur.	

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S270	Continued From page 1 comprehensive assessment used as a care-planning tool) dated 4/17/2023 reveals that Resident #1 has a BIMS [brief interview for mental status] score of 11 indicating a moderate cognitive impairment. Section G, which assesses a resident's most dependent activities of daily living (ADLs) performance and support provided to compete an ADL, reveals that Resident #1 is independent and requires no support for transfer, walking, personal hygiene, or toileting; is independent with eating and dressing and requires set up assistance; and takes showers with supervision and set up assistance. Resident #1's care plan for basic care needs, last updated on 4/16/2023, reveals "I am independent with my own care, but the staff have noticed that I am wearing the same clothes over and over and at times they are over worn and are in disrepair and sometimes dirty," and includes the following interventions: "I bathe with supervision and Ax1 [one person assist] for thoroughness ... I transfer without help ... I move about the neighborhood without help and use of rollator [wheeled walker] ... I need everyone to honor my likes and dislikes, give me cues." Resident #1's basic care goals are to "maintain my ability to complete my cares independently as possible." On 6/6/2023 at 9:36 AM Resident #1 was observed sitting in a chair in his/her room. There was bilateral bruising on his/her forearms. His/her left arm had multiple bruises ranging from thumb print size to three inches in diameter, and his/her right arm had a large, raised bruise from the wrist to the elbow approximately 3 inches wide by 12 inches long. When asked about how s/he got the bruises, Resident #1's body language became tense and s/he stated that s/he is not sure, but it hurt and that I should ask the staff. When asked	S270	The Director of Health & Resident Services (DHRS) or designee will conduct audits via the use of interviews with residents and staff weekly x3 months to monitor effectiveness of this plan. Findings will be brought to CQI meetings. After 90 days, the DHRS will determine the continued duration of audits. Corrective action will be completed by 7/14/23. **Tag S270 POC accepted on 7/5/23 by S. Stem/P. Cota**	

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S270	Continued From page 2	S270		

about his/her showering habits and what s/he needed for staff assistance, s/he explained that s/he does get help in the shower sometimes but does not want it because s/he can do it on her own. Resident #1 then got out of his/her chair and walked to the bathroom without an assistive device to show this surveyor his/her bathroom and explain that s/he can still do things on his/her own.

Per a 6/5/2023 note by the Director of Nursing (DON), facility leadership investigated an incident occurring on 6/5/2023 regarding a report of combative behavior from Resident #1 while being unwillingly showered. The note reveals that "[LNA #1] reported that the resident has marked body odor and had not had a shower recently. The resident refused again today, but [LNA #1] was under the impression that it was imperative to get the resident showered ... I [DON] told [LNA #1] that providing care over a resident's objection is never permissible and that we would need to change our system to provide alternative to washing unwilling residents."

On 6/6/2023 at approximately 10:00 AM, LNA #1 explained that Resident #1 has been refusing showers at an increasing rate. S/He stated that yesterday [6/5/2023] Resident #1 refused to take a shower multiple times, but s/he got the resident to go to the shower room with him/her. S/He explained that s/he washed the top part of Resident #1's body and was attempting to transfer him/her into a lift to wash the lower part of his/her body when the resident became combative and was physically resisting the shower. LNA #1 called for help from another LNA [LNA #2]. They wiped down Resident #1 and brought him/her back to his/her room. A signed statement from LNA #1, giving more detail about

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S270	Continued From page 3 how Resident #1 got to the shower room and how s/he continued to shower the resident while s/he was physically refusing, reveals the following: "I helped [him/her] into a wheelchair to take [him/her] into the shower. [S/He] was saying [s/he] did not want to shower but was not combative. When I started to wash her upper body, [s/he] became combative, hitting me and flailing around and yelling. I was trying to get [him/her] into the standing lift to wash [his/her] lower part of [his/her] body, when another aide, [LNA #2] came into the room ..." A signed witness statement from LNA #2 dated 6/7/2023 states: "I heard a commotion in the shower room, and I heard [Resident #1] shouting. I went into the shower room and found [LNA #1] trying to shower [Resident #1], who was flailing [his/her] arms around hitting the shower wall and fixtures and being combative. [LNA #1] wanted to use the stand-lift to clean [Resident #1's] lower body. [Resident #1] was saying [s/he] didn't want a shower and didn't want to use the lift." The facility's internal investigation of incident summary dated 6/12/2023 reveals under "factual findings" that "By the time [Resident #1] returned to [his/her] room, [Resident #1] had extensive dark bruising on both forearms and a hematoma on [his/her] right forearm. [S/He] was distrustful and withdrawn and indicated that staff had been responsible for [his/her] bruises." The conclusion of the facility investigation summary reveals that Resident #1 had undoubtedly refused a shower and was known to refuse showers. The facility finds that [LNA #1] "did not properly differentiate between [Resident #1's] verbal and physical cues that [s/he] did not want to shower and [Resident #1's] ordinary reluctance to take a shower ... It does appear, however, that [Resident #1] was	S270		

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S270	Continued From page 4	S270		

given a shower over [his/her] objection leading to [him/her] increased agitation and injury in the shower."

A facility incident report prepared by an LPN on 6/5/2023 states that Resident #1 "looked as if [s/he] felt hopeless and afraid," and that Resident #1 was "unwilling to talk with nursing, social worker, and activities director. [S/He] only states [s/he] doesn't want to live here anymore [s/he] wants to move back to FL." The report reveals that Resident #1 was oriented to person and place and had no predisposing physiological factors.

A signed witness statement from a Licensed Practical Nurse (LPN), dated 6/13/2023, reveals that Resident #1 usually needs to be asked a few times to get into the shower but generally walks, and states that when s/he walked into Resident #1's room "[Resident #1] was in [his/her] wheelchair with [his/her] pants 3/4ths of the way up with towels covering [his/her] lap, [his/her] arms wrapped with [his/her] head hanging into them. [S/He] would not speak to me or look at me and I noticed bruising on [his/her] arm. [S/He] would not tell me what happened."

A 6/5/2023 Nurse Practitioner note reveals the following: "I met with [Resident #1] today after nursing alerted me of a large hematoma on [his/her] right forearm .... [Resident #1] tells me [s/he] isn't sure what happened but now [his/her] arm hurts. [S/He] said that it is painful especially when it is touched ... [s/he] has bruising extends from [his/her] dorsal [upper side] hand towards [his/her] elbow."

On 6/6/2023 at 8:45 AM, an LNA who is familiar with Resident #1 stated that Resident #1 has a

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S270	Continued From page 5 long history of refusing to take a shower. S/He will sometimes go without a shower for up to two weeks and the appropriate intervention is to offer [him/her] a bed bath, which might also be refused. The LNA stated that Resident #1 is independent but still needs staff for supervision and cuing for a shower. During an interview with the DON and Administrator on 6/6/2023 at 2:10 PM, the DON confirmed that what LNA #1 had done to Resident #1 "was not okay," and "s/he should have stopped when the resident said no." Per the Administrator, the following documents outline resident rights: Resident Rights policy states: "At a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident. You have the right to: Be treated with respect: You have the right to be treated with dignity and respect, as well as make your own schedule and practice in activities as you choose. You have the right to decide when to go to bed, rise in the morning, and eat your meals." Facility procedure titled "Residents' Rights and Nursing Facility Grievance Procedure" states: "You have the right to refuse care or treatment, to the extent permitted by law, and to know what may happen if you refuse." On 6/6/2023 at 4:08 PM, the Nurse Educator confirmed that all staff are trained annually in resident rights which includes the right for a resident to refuse care at any time. On 6/6/2023 at approximately 5:00 PM, the DON confirmed that Resident #1's care plan does not address his/her refusal of showers care in their preferences, approaches, or goals. See S297 for more information regarding failure to develop and	S270		

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S270	Continued From page 6 revise comprehensive care plans.	S270		
S297 SS=G	6.1 (a) COMPREHENSIVE CARE PLANS - DEVELOPMENT 6.1 (a) The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: 1. the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being as required under Section 7; and 2. any services that would otherwise be required under Sections 3 and 4 but are not provided due to the resident's exercise of rights, including the right to refuse treatment. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to implement care plan interventions that honored a resident's goals to maintain independence related to activities of daily living; and failed to revise a care plan to include refusal of care and approaches to care that protect a resident from skin injury for 1 applicable resident (Resident #1). These failures resulted in extensive bruising, physical pain, and emotional distress for Resident #1. Findings include: Record review reveals that Resident #1 was admitted to the facility on 6/14/2019 and has diagnoses that include: dementia, essential	S297	S297 Staff will implement Resident #1's care plan interventions to honor the resident's goals to maintain independence related to activities of daily living. Resident #1's care plan has been updated to include refusal of care and approaches to care that protect the resident from skin injury. All residents have the potential to be affected by the same deficient practice. Care plans will be implemented and revised in accordance with 6.1 (a) Comprehensive Care Plans – Development.	

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S297	Continued From page 7 thrombocythemia, anxiety disorder, and anemia. Resident #1's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 4/17/2023 reveals that Resident #1 has a BIMS [brief interview for mental status] score of 11 indicating a moderate cognitive impairment. Section G, which assesses a resident's most dependent activities of daily living (ADLs) performance and support provided to compete an ADL, reveals that Resident #1 is independent and requires no support for transfer, walking, personal hygiene, or toileting; is independent with eating and dressing and requires set up assistance, and takes showers with supervision and set up assistance. A facility incident report dated 6/4/2023, reveals that Resident #1 became combative while being showered by LNA #1 after s/he had refused a shower on 6/4/2023. As a result, Resident #1 had significant bilateral forearm bruising and was withdrawn with staff, appearing afraid. The facility's internal investigation of incident summary dated 6/12/2023 reveals under "factual findings" that "By the time [Resident #1] returned to [his/her] room, [Resident #1] had extensive dark bruising on both forearms and a hematoma on [his/her] right forearm. [S/He] was distrustful and withdrawn and indicated that staff had been responsible for [his/her] bruises." The conclusion of the facility investigation summary reveals that Resident #1 had undoubtedly refused a shower and was known to refuse showers. The facility finds that [LNA #1] "did not properly differentiate between [Resident #1's] verbal and physical cues that [s/he] did not want to shower and [Resident #1's] ordinary reluctance to take a shower ... It does appear, however, that [Resident #1] was given a shower over [his/her] objection leading to	S297	Staff responsible for the implementation and revision of care plans will be educated in accordance with State Regulation 6.1 (a) Comprehensive Care Plans – Development to ensure the deficient practice will not recur. A process will be implemented that ensures every care plan is reviewed as needed and at minimum monthly. The Director of Nursing (DNS) or designee will conduct audits of care plans weekly x3 months to monitor the effectiveness of this plan. Findings will be brought to CQI meetings. After 90 days, the DNS will determine the continued duration of audits. Corrective action will be completed by 7/14/23. **Tag S297 POC accepted on 7/5/23 by S. Stem/P. Cota**	

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S297	Continued From page 8 [him/her] increased agitation and injury in the shower." The facility's internal investigation includes a Licensed Practical Nurse (LPN) statement that reveals that Resident #1 usually needs to be asked a few times to get into the shower but generally walks, and states that when s/he walked into Resident #1's room "[Resident #1] was in [his/her] wheelchair with [his/her] pants 3/4ths of the way up with towels covering [his/her] lap, [his/her] arms wrapped with [his/her] head hanging into them. [S/He] would not speak to me or look at me and I noticed bruising on [his/her] arm. [S/He] would not tell me what happened." 1. Resident #1's care plan goal to maintain independence for care needs was not followed by staff. Resident #1's care plan for basic care needs, last updated on 4/16/2023, reveals "I am independent with my own care, but the staff have noticed that I am wearing the same clothes over and over and at times they are over worn and are in disrepair and sometimes dirty," and includes the following interventions: "I bathe with supervision and Ax1 [one person assist] for thoroughness ... I transfer without help ... I move about the neighborhood without help and use of rollator [wheeled walker] ...I need everyone to honor my likes and dislikes, give me cues." Resident #1's basic care goals are to "maintain my ability to complete my cares independently as possible." On 6/6/2023 at 9:36 AM, Resident #1 was observed sitting in a chair in his/her room. There was bilateral bruising on his/her forearms. His/her left arm had multiple bruises ranging from thumb print size to three inches in diameter, and his/her	S297		

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S297	Continued From page 9 right arm had a large, raised bruise from the wrist to the elbow approximately 3 inches wide by 12 inches long. When asked about how s/he got the bruises, Resident #1's body language became tense and s/he stated that s/he is not sure, but it hurt and that I should ask the staff. When asked about his/her showering habits and what s/he needed for staff assistance, s/he explained that s/he does get help in the shower sometimes but does not want it because s/he can do it on her own. Resident #1 then got out of her chair and walked to the bathroom without an assistive device to show this surveyor his/her bathroom and explain that s/he can still do things on his/her own. Per a signed statement from LNA #1 regarding the incident on 6/5/2023, LNA #1 reveals that Resident #1 had refused to shower on 6/5/2023. LNA #1 brought Resident #1 to the shower room in a wheelchair. Resident #1 became combative while having his/her upper body washed by LNA #1. LNA #1 attempted to get Resident #1 into a standing lift in order to wash Resident #1's lower body, while Resident #1 was physically refusing. A signed witness statement from LNA #2 dated 6/7/2023 states: "I heard a commotion in the shower room, and I heard [Resident #1] shouting. I went into the shower room and found [LNA #1] trying to shower [Resident #1], who was flailing [his/her] arms around hitting the shower wall and fixtures and being combative. [LNA #1] wanted to use the stand-lift to clean [Resident #1's] lower body. [Resident #1] was saying [s/he] didn't want a shower and didn't want to use the lift." On 6/6/2023 at 8:45 AM, an LNA who is familiar with Resident #1 stated that Resident #1 is independent in his/her care but still needs staff for	S297		

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S297	Continued From page 10 supervision and cuing for a shower. A signed statement from an LPN dated 6/13/2023 reveals that Resident #1 generally walks to the shower. Review of nursing notes since Resident #1's last MDS on 4/17/2023 reveal a 5/14/2023 nurse note stating that Resident #1 "is noted to be needing more verbal cues and direction to stay on tasks such as getting dressed, coming to meals, and with accepting showers etc." There are no notes indicating that Resident #1 has declined in his/her ability to ambulate or needing a wheelchair to move about the neighborhood. 2. Resident #1's care plan was not updated to reflect frequent refusal of showers and interventions to meet her showering and/or bathing needs. On 6/6/2023 at 8:45 AM, an LNA who is familiar with Resident #1 stated that Resident #1 has a long history of refusing to take a shower. S/He will sometimes go without a shower for up to two weeks and the appropriate intervention is to offer [him/her] a bed bath, which might also be refused. Review of Resident #1's care plan does not address refusal of showers or include interventions to address refusal of showers and should. A signed statement from an LPN dated 6/13/2023 reveals that Resident #1 usually refuses showers and needs to be reapproached several times. On 6/6/2023 at approximately 5:00 PM, the	S297		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKE ROBIN-LINDEN NURSING HOME	200 WAKE ROBIN DRIVE SHELBURNE, VT 05482

(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
S297	Continued From page 11 Director of Nursing (DON) confirmed that Resident #1's care plan does not address his/her refusal of showers care in their preferences, approaches, or goals. 3. Resident #1's care plan did not include interventions related to his/her diagnosis of thrombocythemia that would address maintaining their skin integrity while assisting with ADLs or refusal of care. Resident #1's care plan, last updated on 4/16/2023, reveals the following needs/preferences and approaches to care: "I have the potential to have a skin injury, bruising and bleeding because I lose my balance sometimes and can fall or bump into things and take a medication that causes me to bruise easily. I have essential thrombocythemia." There are no interventions on how to prevent skin issues, such as bruising, when helping assist the resident with basic care needs or when the resident is refusing care. On 6/6/2023 at approximately 5:00 PM, the DON confirmed that Resident #1's care plan does not include interventions to protect his/her skin when assisting with care or during refusal of care and should.	S297		