

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

December 2, 2015

Mr. Randy Crowder, Administrator
Bennington Health & Rehab
2 Blackberry Lane
Bennington, VT 05201-2300

Dear Mr. Crowder:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 4, 2015**. 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



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

PRINTED: 11/18/2015
FORM APPROVED
OMB NO. 0938-0391

DEC - 1 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2015
NAME OF PROVIDER OR SUPPLIER BENNINGTON HEALTH & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 2 BLACKBERRY LANE BENNINGTON, VT 05201	
(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)

F 000 INITIAL COMMENTS

An unannounced onsite annual recertification survey was conducted by the Division of Licensing & Protection on 11/2-11/4/2015. The following are regulatory findings.

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

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:

Based on observation and staff and resident interview, the facility failed to promote care for residents in a manner that maintains or enhances each resident's dignity and respect for 8 residents in the total sample. (including Residents #11, #86, #109, #234, #133) Findings include:

1. Per observation on 11/2/15 at 3:37 PM, a Licensed Nursing Assistant (LNA) was in the room of Resident #11, when his/her roommate, accompanied by the surveyor pushed open the door. Resident #11 was partially exposed and the privacy curtain was not pulled. It was confirmed at this time, by the LNA, that the privacy curtain was not pulled.

2. Per observation on 11/2/15, during provision of catheter care for Resident #86 between 3:38 and 3:42 PM, the LNA called the resident "sweetie" 3 times and "sweetheart" twice. The LNA confirmed that it is not dignified or respectful. Also, on 11/3/15 at 4:28 PM staff was heard

F 000

F 241

This plan of correction does not imply agreement with the citation. It is completed as required by state and federal regulations.

F 241 483.15(a)

1. Resident #11, #86, #109, #234 and #133 had no negative outcome as a result of the alleged deficient practice
2. Residents residing in the facility have the potential to be affected by the alleged deficient practice
3. Education will be provided to the staff regarding privacy requirements, dignity and respect
4. Weekly audits will be conducted by the DNS or designee to monitor the effectiveness of the plan
5. Results of the audits will be reported at the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits
6. Corrective action will be completed by 11/25/2015

F241 POC accepted 12/2/15 mt Higgins Pdl/PMC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Director* (X5) DATE *11/23/15*

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 241 Continued From page 1
calling Resident #86 "sweetie". Per interview with the resident at 4:31 PM, s/he said that s/he doesn't think the staff means anything by it, but s/he doesn't like it, that s/he is just too old for that.

3. Per observation on 11/4/15, the dining room LNA was observed calling 3 residents "hun". At 8:37 AM, the LNA said to Resident #109, who had approached another resident and was touching his/her arms, "No, [resident name] doesn't like that hun" and redirected him/her to the dining table. Between 8:40 AM and 8:42 AM the LNA called Resident #234 "hun" when referring to having them eat some of their breakfast. At 8:44 AM, the LNA then referred to Resident #133 as "hun". At 8:45 AM the LNA confirmed that s/he often calls the residents "honey" and that s/he knows s/he is not supposed to.

4. Per observation between 8:35 AM and 8:55 AM on 11/4/15, an LNA was feeding 3 residents at the same table at the same time while standing. S/he was also multi-tasking by assisting other residents in the dining room by providing them with drinks, verbal cueing, giving toast, oatmeal, and a bagel. S/he was not seated and walked around the table to accomplish the task. S/he confirmed at 8:55 AM that s/he was suppose to be feeding only one resident at a time and was to be seated when doing so.

F 241

F 253 : 483.15(h)(2) HOUSEKEEPING & SS=E MAINTENANCE SERVICES

F 253

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

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This REQUIREMENT is not met as evidenced by:

Based on observations and staff interviews the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable environment and care equipment. Findings include:

1. During the initial tour on 11/02/15 at 10:40 AM resident care equipment and/or rooms were not clean as follows:

- a) dirty bedside stands with dried spills/stains in rooms 216, 220, 222, 224, & 226;
- b) wall fans with a build up of dust in rooms 316, 222, 223;
- c) bathroom ceiling vents filled with dirt and dust in rooms 319, 210, 302;
- d) a hole in the wall of room 208;
- e) the toilet in room 220 had dried feces in and around the bowl.

Per interview on 11/03/15 at 9:56 A.M. the Director of Housekeeper, stated that every day the two housekeeping staff are responsible for cleaning the whole building. At this time the nurse surveyor pointed out the above area and the Housekeeper Director confirmed the above findings.

2. Per observation on 11/2/15, linen carts and mechanical stand lift equipment were in the North hall between rooms 304 and 305 and the South hall between rooms 322 and 323 on the third floor, and they had not been moved for over an hour. On 11/3/15 at 8:50 AM the linen carts and stand lifts were still in the same places. Per interview at 9:17 AM the Licensed Nursing Assistant (LNA) stated that the stand lifts are

F 253

F253 483.15(h)(2)

1. No residents were negatively affected as a result of the alleged deficient practice
2. All identified bedside stands in rooms were cleaned. All identified wall fans in rooms were cleaned. All identified bathroom ceiling vents in rooms were cleaned. The identified hole in wall was repaired. The identified toilet in room was cleaned. The facility has reviewed and revised the process in which equipment is stored. Environmental rounds have been conducted to ensure other areas are not affected.
3. Residents residing in the facility have the potential to be affected by the alleged deficient practice
4. Education will be provided to staff regarding requirements to maintain a sanitary, orderly, and comfortable interior. Education provided to staff regarding storage of equipment
5. Weekly audits will be conducted by the ED or designee to monitor the effectiveness of the plan
6. Results of the audits will be reported at the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits
7. Corrective action will be completed by 11/25/2015

F253 POC accepted 12/2/15 mtg jgr/pme

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used very little on the third floor and it is stored in the hall. At 10:00 AM a staff member from laundry brought a large linen cart to the unit and replaced linen to each of the individual carts that were in the hall. At 4:55 PM an LNA stated that "the linen carts and stand lifts are kept in the hall, but the lifts can go in the shower room, but they usually aren't put there because there isn't much room in there". S/he further confirmed that the stand lifts are kept in the hall.

F 279 SS=D 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must 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 services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and record

F 253

F 279

F279 483.20(d), 483.20(k)(1)

1. Resident #11 and #56 had no negative outcome as a result of the alleged deficient practice. A comprehensive care plan was written to include depression, diabetes and indwelling catheter for resident #11. A comprehensive care plan was written to include dentition for resident #56.

2. Residents residing in the facility have the potential to be affected by the alleged deficient practice

3. Education will be provided to Licensed nursing staff regarding requirements for developing, reviewing, and revising resident's comprehensive plan of care

4. Weekly audits will be conducted by the DNS or designee to monitor the effectiveness of the plan

5. Results of the audits will be reported at the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits

6. Corrective action will be completed by 11/25/2015

F279 POC accepted 12/2/15 Mitigins Rdl/PMC

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F 279 . Continued From page 4

review, the facility failed to develop a plan of care for 2 residents of the 21 residents in the Stage 2 survey sample. Resident #11 regarding depression, diabetes and indwelling catheter and Resident #56 who has missing teeth. Findings include:

1. Per record review, Resident #11 has diagnoses of Major depressive disorder, retention of urine and Type 2 diabetes. Resident observation on 11/3/15 presents that s/he has an indwelling Foley catheter. Per record review of physician orders, s/he is to receive Foley catheter care every shift; have chemstick (blood test for glucose levels) done twice a day, three times a week; Lantus SoloStar Solution Pen-injector (insulin) 100 Unit/ml 6 Units at bedtime; Escitalopram 5 mg daily for depression and Tamsulosin HCL 0.4 mg PO (by mouth) daily for enlarged prostate. There is no evidence of care plans with measurable objectives and timetables and specific interventions to address depression, indwelling foley catheter or diabetes as confirmed by the Director of Nurses at 3:31 PM. It was also confirmed that the Minimum Data Set information presents that the resident triggers for care planning in these areas.

2. Per observation at 9:30 AM on 11/4/15 Resident #56 is noted to have multiple missing teeth. S/he states in an interview, at that time, that s/he has had missing teeth a long time and doesn't like dentists. In a review of the resident's

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F 279 Continued From page 5
record there is no notation of his/her missing teeth in the notes. A discontinued care plan in the EMR (Electronic Medical Record) from a previous admission, dated 3/26/15 does include the missing teeth in both the Nutrition and Dysphagia care plans sections. In an interview with the UM on 11/4/15 at 2:15 PM s/he confirmed that there is no care plan for dental needs in the record.

F 279

F 282 SS=E 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

F 282

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 observation, staff interview and record review, the facility failed to provide services in accordance with the plan of care for 3 of 21 residents in the stage 2 sample (Resident #4, #88 and #86). Findings include:

1. Resident #4 did not receive accurate wound monitoring and documentation according to the the plan of care. Resident #4 was admitted on the evening of 09/30/15 with a pressure sore to his/her coccyx area. There is no initial nursing assessment that shows the wound size. The care plan directs staff to administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing [weekly], Measure length, width and depth where possible. Document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the physician.

F282 483.20(k)(3)(ii)

1. Resident #4 is no longer residing in the facility. Resident #44's bruise is showing signs of resolution without complication. Resident #86 had no negative outcome as a result of the alleged deficient practice.
2. Residents requiring skin assessment and special devices have the potential to be affected by the alleged deficient practice
3. Education will be provided to staff regarding requirement of skin assessment and special care devices in accordance with each resident's written plan of care
4. Weekly audits will be conducted by the DNS or designee to monitor the effectiveness of the plan
5. Results of the audits will be reported at the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits

6. Corrective action will be completed by 11/25/2015

F382 POC accepted 12/2/15 M Higgins RN/PMC

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The weekly wound measurement sheet shows that only two, the first on 10/01/15 & (late) 10/12/15 measurements were obtained during the month of October 2015. No other nursing wound measurements were found in either the paper copy or electronic chart. The resident was discharged on 11/02/15 with a nursing note dated 11/01/15 stating "dressing change to coccyx area much improved." The MDS Coordinator on 11/04/15 at 1:30 PM confirmed that there is no evidence that staff, although doing dressing changes as ordered, documented/measured the wound on a weekly basis, noting the type, length, width, depth and drainage of the wound. The Unit Manager at 3:30 PM confirmed the above findings.

2. Facility staff did not follow the plan of care for Resident #44 by failing to consistently assess the skin, failing to document a bruise and failing to alert the physician. During observation on 11/03/15 at 11:29 A.M., a half dollar size bruise (fading black and blue) was near the upper and lateral [outer] side of the left eye. The resident, during interview at that time, was unable to state how the bruise was obtained. Review of the current care plan dated 09/23/15 shows that the resident's skin is at risk for bruising and bleeding. The care plan directs staff to monitor and notify the physician or any skin tears, bruising and bleeding, and to follow facility protocol for skin assessments.

Per record review, the resident was admitted on 02/26/15 and a full nursing skin assessment was completed. However, during the last quarterly assessment (09/23/15) no nursing skin assessment was found nor did the MDS

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F 282 Continued From page 7

[minimum data set] identify any skin issues. Additionally, nursing notes for the last month did not identify any bruising to the left eye or notification to the physician for skin concerns.

Per interview on 11/03/15 at 2:20 P.M. the staff nurse stated "I think it happened the other day...over the weekend". The nurse also stated that the resident frequently bumps [his/her] head on the siderails and staff are aware via the shift reports. Review of the weekend shift report and nursing notes for greater than one week does not mention bruising for this resident.

During interview on 11/03/15 at 3:27 P.M. the DNS stated "we are supposed to do an assessment at least every quarter and/or when there is a new skin issue and to fax the physician with information about skin concerns". S/he confirmed at this time that staff did not follow the plan of care for this resident.

3. Per record review, Resident #86 has a diagnosis of hemiparesis/hemiplegia (weakness in one side of the body) secondary to cerebral vascular disease. Care plan for hemiplegia/hemiparesis related to stroke states to perform Range of motion (ROM) (active or passive) with am/pm care daily. During observation of morning care at 9:46 AM on 11/3/15, the Licensed Nursing Assistant (LNA) failed to perform ROM. Per interview with the LNA at this time, s/he stated that they do not usually work the unit and that s/he was not familiar with the care. After reviewing the care plan with the LNA s/he confirmed that they had

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F 282 Continued From page 8
not provided ROM per care plan.

4. Review of Resident #86 care plans presents a care plan dated 9/14/14 regarding risk for skin breakdown secondary to limited mobility states to have heel bo to right elbow to prevent pressure from occurring, and to have heels elevated off bed. Observation of resident on 11/3/15 at 3:16 PM presented the resident without heels being elevated off the bed and without a right heel bo to the right elbow. The LNA stated that the resident requires total assist with positioning and confirmed at 3:25 PM that the heels of Resident #86 were with heel protectors, but they were not elevated off the bed. The Licensed Practical Nurse confirmed at this time that the resident does not have anything under his right elbow and that his heels were not elevated per the care plan.

5. Resident #86 has a care plan dated 9/30/15 that indicates staff is to place on the resident a right thumb/wrist orthotic daily during mealtimes and the resident is to wear the orthotic 3 times a day for up to 1 hour each time. Per observation the resident did not have it in place at breakfast 11/3/15, nor was it in place at lunch. The resident also did not have the orthotic in place during observation of breakfast meal on 11/4/15. Interview with the Occupational Therapist on 11/3/15 at 4:05 PM presented that the resident was fitted for the orthotic and the care plan was put into effect the end of September. It was confirmed by the LNA that s/he had not used the orthotic on either days per care plan.

F 309 483.25 PROVIDE CARE/SERVICES FOR
SS=E HIGHEST WELL BEING

Each resident must receive and the facility must

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F 309

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provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interviews the facility failed to assure that care and services were provided to attain or maintain the highest practicable well-being for 3 residents (Residents #110, 86 & 56) in a Stage 2 sample of 21. Findings include:

- Per observation on 11/2/15 at 12:50 PM Resident #110 was noted to have a large purple bruise on the his/her Left Lower Jaw. The resident is non-interviewable and unable to specify where the bruise originated. In a review of the resident's record, the most recent Skin Evaluation dated 8/21/15 simply states that skin is intact with no mention of bruising. In a review of all assessments there is no assessment discussing the bruising. In a review of nursing notes there is no mention of a bruise. In an interview on 11/4/15, the Unit Manager confirmed that s/he first noted the bruise on the morning of 11/4/15 and it was not reported any earlier by any other staff. In an interview at 2:30 PM the UM confirmed that there were no notes regarding the bruise in the record nor was there any identifiable assessment of the wound found.
- Per observation on 11/4/15 at 9 AM Resident #56 was noted to have a large purple and

F 309

F309 483.25

- Resident #110's bruise is showing signs of resolution without complication. Resident #56's bruise is showing signs of resolution without complication. Resident #86 had no negative outcome as a result of the alleged deficient practice.
- Residents requiring skin assessment and range of motion have the potential to be affected by the alleged deficient practice
- Education will be provided to staff regarding requirements of skin assessment and special care services in accordance with each resident's written plan of care
- Weekly audits will be conducted by the DNS or designee to monitor the effectiveness of the plan
- Results of the audits will be reported at the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits
- Corrective action will be completed by 11/25/2015

F309 PDC accepted 12-11-15 mtg ginsrw/pme

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2015
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NAME OF PROVIDER OR SUPPLIER BENNINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2 BLACKBERRY LANE BENNINGTON, VT 05201
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F 309 Continued From page 10
 yellowish bruise on the back of his/her right hand. The resident stated that s/he had no idea where the bruise came from. In a review of the resident's record, a notation in the admission note, states that the resident has a bruise on his R hand at the time of admission. The Skin Evaluation reports found in the record all state there are no new issues. There is no mention of any bruising in the nurses notes. During an interview at 2:30 PM the UM confirmed that there were no notes regarding the bruise in the record nor was there any identifiable assessments of the bruise found.

3. Resident #86 has a diagnosis of hemiparesis/hemiplegia (weakness in one side of the body) secondary to cerebral vascular disease. Care plan for hemiplegia/hemiparesis related to stroke states to perform Range of motion (ROM) (active or passive) with am/pm care daily. During observation of morning care at 9:46 AM on 11/3/15, the Licensed Nursing Assistant (LNA) failed to perform ROM. Per interview with the LNA at this time, s/he stated that they do not usually work the unit and that s/he was not familiar with the care. After reviewing the care plan with the LNA s/he confirmed that they had not provided ROM per care plan. Per interview with the Physical Therapist Director on 11/4/15 at 11:02 AM, the resident does not have a contracture and s/he is to have Passive Range of Motion to maintain the functionality of his/her right shoulder, elbow and wrist and to prevent contractures.

F 309

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PRINTED: 11/18/2015
FDRM APPROVED
OMB NO. 0938-0391

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F 353 Continued From page 11
F 353 483.30(a) SUFFICIENT 24-HR NURSING STAFF
SS=E PER CARE PLANS

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.

Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:

Based on observation and resident and staff interview the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Findings include:

1. Per interview on 11/3/13 at 9:46 AM, Licensed Nursing Assistant (LNA) #1 stated that s/he still had quite a few residents to do morning care for. S/he stated that there are 42 residents on the unit

F 353
F 353

F353 483.30(a)

1. There were no negative outcomes as a result of the alleged deficient practice.
2. Residents residing in the facility have the potential to be affected by the alleged deficient practice
3. Facility administration will continue to review daily staffing to ensure it is adequate to meet the needs of the residents
4. Education will be provided to the staff regarding the need to communicate challenges with completing care to the unit manager/DNS
5. Weekly audits will be conducted by the DNS or designee to monitor the effectiveness of the plan
6. Results of the audits will be reported at the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits
7. Corrective action will be completed by 11/25/2015

F353 POC accepted 12/2/15 mtiggins RN/pme

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F 353	<p>Continued From page 12</p> <p>and usually there are only 4 LNAs and his/her assignment consisted of 12 residents, 8 of them were extensive or total assistance and 2 of them needed showers. Lunch trays were passed at 12:45 PM and the LNA still had several residents to do morning care on. At 2:20 PM, LNA #1 was returning Resident #345 to his/her room after giving them a shower and stated that s/he was finally finished with his/her assignment. (LNA's shift ended at 3:00 PM) Resident #345 stated that it was about time and that s/he was glad that they finally got their shower and s/he said that s/he doesn't like to wait that long to take one. At 3:10 PM LNA #1 said that it is also the responsibility of the LNAs to pass trays and feed residents and that usually takes another hour and a half to 2 hours from the day.</p> <p>2. On 11/4/15 per observation between 8:35 AM and 8:55 AM, LNA #2 was feeding 3 residents at the same table at the same time while standing. S/he was also multi-tasking by assisting other residents in the dining room by providing them with drinks, verbal cueing, giving toast, oatmeal, and a bagel. S/he was not seated and walked around the table to accomplish the task. S/he confirmed at 8:45 AM that s/he was supposed to be feeding only one resident at a time and s/he was to be seated when she was doing it. S/he further stated that that, "if you could clone yourself, then there might be enough help to get everything done the right way".</p> <p>3. During Stage 1 of the survey, Resident #86, who has a diagnosis of depression, made the following statement during the resident interview, "like today I didn't get my lunch until after 1 PM and I was hungry, they just ignore me". H/she further stated that sometimes it takes</p>	F 353		
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F 353 Continued From page 13
a very long time for someone to come in when s/he rings their call light. During observation on the unit staff went into the resident's room only to provide care, food or medications.

F 353

F 356
SS=B 483.30(e) POSTED NURSE STAFFING INFORMATION

F 356

The facility must post the following information on a daily basis:

- o Facility name.
- o The current date.
- o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
 - Registered nurses.
 - Licensed practical nurses or licensed vocational nurses (as defined under State law).
 - Certified nurse aides.
- o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:

- o Clear and readable format.
- o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

F356 483.30(e)

1. No residents were negatively affected as a result of the alleged deficient practice
2. The facility administration has reviewed and revised the process of posting nurse staffing information and education has been provided to those involved.
3. Weekly audits will be conducted by the DNS or designee to monitor the effectiveness of the plan
4. Results of the audits will be reported at the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits
5. Corrective action will be completed by 11/25/2015

F356 PDC accepted 12/2/15 M Higgins Rd/Amc

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F 356 Continued From page 14
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility had not posted daily staffing information with the current date at the beginning of each shift. Findings include:

On the second day of survey, 11/3/15 at 10:55 AM, it was observed that the daily staffing information had not been posted to reflect the accurate date, census and staffing. The 11/2/15 posting was still being displayed. On 11/4/15 at 8:15 AM (2 hours after the start of the shift), the posting displayed the date of 11/2/15 with no reflected changes with census or staffing. Per interview with the administrator at this time, s/he confirmed that the daily posting was dated 11/2/15 and s/he was correcting it right now. S/he further stated that it was not posted correctly because the person that is responsible for posting had gone home early yesterday. Per interview with the Director of Nurses at 9:55 AM, the daily staffing information is not usually posted until 9:30 AM and not at the beginning of the shift.

F 356

F 371 483.35(j) FDDD PROCURE,
SS=E STORE/PREPARE/SERVE - SANITARY

F 371

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

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F 371 Continued From page 15
This REQUIREMENT is not met as evidenced by:
Based on observations and interviews the facility failed to store, prepare, distribute and serve food under sanitary conditions. This has the potential to effect all residents in the facility. Findings include:

Per observation during the initial tour on 11/02/15 at 10:51 AM with the Food Service Supervisor (FSS), the facility failed to prepare, distribute and serve food under sanitary conditions as follows:

a) Not all food items were labeled, and/or outdated items removed in the kitchen's reach-in refrigerator. Several containers of outdated drinks such as Lemonade and iced tea (dated 10/28/15) as well as a plate of eaten food, which was covered but did not have a label or date. In addition, a build up of food debris was noted between on the food prep table and lip/hinge areas and sticky substance near the juice dispenser.

b) The resident nourishment refrigerator on the third floor had 6 drink containers outdated since 10/31/15 and old cottage cheese dated 10/30/15.

c) The resident nourishment refrigerator on the third floor was noted to have 3 containers of juice dated 10/31/15 along with cottage cheese and regular cheese outdated since 10/30/15. Per interview at that time the dietary aid acknowledged that the food items "should've been removed but [they] usually don't have the staff on the weekends to do that, so maybe they didn't get to it".

F 371 F371 483.35(i)

1. No residents were negatively affected as a result of the alleged deficient practice

2. Residents residing in the facility have the potential to be affected by the alleged deficient practice

3. All identified products were disposed of. The debris between the tables was cleaned.

4. Education will be provided to staff regarding requirement of storing, preparing, distributing, and serving food under sanitary conditions.

5. Weekly audits will be conducted by the ED or designee to monitor the effectiveness of the plan

6. Results of the audits will be reported at the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits

7. Corrective action will be completed by 11/25/2015

F371 POC accepted 12/2/15 mHiggins pdl/pmc

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F 371 Continued From page 16
 During the return visit on 11/03/15 at 2:30 PM shows sticky and/or dried dark liquid on counter near the juice dispenser as well the food prep tables had a build up a dried food debris the lip of the table and in between the tables. This was confirmed by the FSS at that time.

F 411 483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS
 SS=D

The facility must assist residents in obtaining routine and 24-hour emergency dental care.

A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.

This REQUIREMENT is not met as evidenced by:

Based on observation, interviews and record review the facility failed to provide routine dental services for 1 of 3 applicable residents. (Resident #117) Findings include:

1. Per observation and interview on 11/03/15 at 10:39 AM, Resident #117 was noted to have missing, chipped or carious teeth. This resident stated that [his/her teeth] "were bothering me, I think I have a cavity because they hurt when I chew on something hard". The resident also

F 371

F 411 F411 483.55(a)

1. Upon admission resident #117 was noted by speech therapist to have poor dentition was not interested in a dental consult. Resident has been seen by the dentist and continues to be followed.
2. Residents with poor dentition have the potential to be affected by the alleged deficient practice
3. Education will be provided to staff regarding requirement of oral assessment and providing dental services, timely.
4. Weekly audits will be conducted by the DNS or designee to monitor the effectiveness of the plan
5. Results of the audits will be reported at the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits
6. Corrective action will be completed by

11/25/2015

F411 POC accepted 12/2/15 MHiggins RN/PMC

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F 411	<p>Continued From page 17</p> <p>stated, when asked if the facility is taking care of these problems to [your] satisfaction, "not fast enough but they're aware now". Per chart review, the resident was admitted on 04/30/15. The History and Physical exam by the physician dated 05/05/15 notes "right side teeth poor repair gums inflamed felt to be [due to] radiation therapy". The initial MDS [Minimum data set] dated 05/07/15 was coded "NO" under section L0200 (c,d,e,f) for missing, broken, cavities, inflamed gum. In addition, the initial nursing assessment in section F(a) also fails to identify broken or carious teeth and notes "own teeth, pink gums/mucous membranes/tongue". There was no specific care plan to address the dental problem noted by the physician other than "to watch and provide dental care" related to bleeding/bruising due to medications.</p> <p>A nursing noted dated 09/24/15 states "resident complaining of not feeling well increased weakness complaining of some mouth discomfort. Noted to have swelling on right side of face, teeth are in decay white abscess area noted as well, MD made aware, order for amoxicillin,[spouse] made aware." The first dental consult was on 10/08/15 and states "this patient's remaining teeth have a poor prognosis..." and suggests extractions and dentures.</p> <p>Per interview on the morning of 11/04/15 the Clinical Manager acknowledged multiple factors such as the failure to identify dental concerns during the initial nursing assessments and MDS and confirmed that dental services were not provide promptly.</p>	F 411		
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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F 431 Continued From page 18
SS=E LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview the facility

F 431

F431 483.60(b), (d), (e)

1. No residents were negatively affected as a result of the alleged deficient practice.
2. Residents residing in the facility have the potential to be affected by the alleged deficient practice.
3. The identified medications were disposed of.
4. Education will be provided to staff regarding requirement of labeling and storing medications
5. Weekly audits will be conducted by the DNS or designee to monitor the effectiveness of the plan
6. Results of the audits will be reported at the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits
7. Corrective action will be completed by 11/25/2015

F431 POC accepted mthiggins RN / pme 12/2/15

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F 431 Continued From page 19

failed to label medications in accordance with accepted professional principles and store controlled drugs in a separately locked, permanently affixed compartment in two of the four medication carts; and one out of the two clean utility rooms located on the second and third floors of the facility. Findings include:

1. Per observation on 11/04/2015 at 11:25 AM of one of the two medication carts (medication cart #1) located on the third floor, there were twelve fentanyl administration cartridges with tubing located in the bottom drawer. These cartridges were not wasted and were not in a separately locked, permanently affixed compartment. Per interview with the third floor Nurse Manager(NM) he/she confirmed that the fentanyl cartridges did not belong in the bottom drawer and that the cartridges should have been wasted immediately after their use. He/she confirmed that the empty cartridges had been in the bottom drawer of the cart for several days.
2. Per observation on 11/04/2015 at 11:25 AM of the top drawer of medication cart #1 a 100 unit/ml Lantus Solostar insulin pen was without a date opened on the label. Per interview with the third floor Nurse Manager (NM) he/she confirmed that there was no date opened on the insulin pen's label and that the pen should have been discarded.
3. Per observation on 11/04/2015 11:37 AM of the third floor clean utility room one bottle of Dakins Solution 0.125% had an expiration date of 8/15 and one bottle of Hydrogen Peroxide had an expiration date of 8/15. Per interview with the third floor NM he/she confirmed that each of the solutions were expired.

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F 431 Continued From page 20

4. Per observation on 11/4/2015 2:18 PM of the second medication cart located on the third floor (medication cart #2) there was one bottle of Colace liquid with an expiration date of 9/15. Per interview with the Licensed Practical Nurse (LPN) working on the medication cart he/she confirmed that the medication had expired.

5. Per observation on 11/4/2015 2:18 PM of medication cart #2 a syringe filled with 30 units/3 cc of heparin was located in the bottom drawer. Per interview with a Licensed Practical Nurse (LPN) the heparin syringe was used for flushing IV's and he/she confirmed that the heparin filled syringe did not belong in the bottom drawer of the cart.

F 441 483.65 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program

The facility must establish an Infection Control Program under which it -

- (1) Investigates, controls, and prevents infections in the facility;
- (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
- (3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

- (1) When the Infection Control Program

F 431

F441 483.65

1. No residents were negatively affected as a result of the alleged deficient practice. Resident #4 does not reside in the facility. Suction machine was cleaned, removed and collection canister was discarded.

F 441

2. Residents residing in the facility have the potential to be affected by the alleged deficient practice

3. Education will be provided to staff regarding requirement of proper procedure to prevent the spread of infection when handling soiled linen. Education will be provided to the Licensed nurses regarding requirements of proper procedure for discarding contents of suction canister.

4. Weekly audits will be conducted by the DNS or designee to monitor the effectiveness of the plan

5. Results of the audits will be reported at the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits

6. Corrective action will be completed by 11/25/2015

F441 POC accepted 12/2/15 mHiggins RLL/PML

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2015
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NAME OF PROVIDER OR SUPPLIER BENNINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2 BLACKBERRY LANE BENNINGTON, VT 05201
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(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) COMPLETION DATE
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determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility failed to provide a sanitary environment to help prevent the transmission of disease and infection. Findings include:

1. On 11/2/15 at 3:14 PM an Licensed Nursing Assistant (LNA) was observed carrying soiled linen from a resident's room through the hall and placing it in the soiled hamper. S/he did not have gloves on, nor was the soiled linen in a protective covering. The LNA confirmed at 3:46 PM that s/he had not worn gloves and that the linen was soiled. Further observations presented that a second LNA was observed at 3:44 PM carrying soiled articles of clothing from a resident's room through the hall to the soiled linen hamper without gloves or protective covering. This LNA confirmed at 3:46 PM that carrying soiled clothing

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or linen is not the accepted practice and that s/he had taken his/her gloves off in the room before coming out with the soiled clothes.

2. In addition, a resident (Resident #4) who was on precaution measures (additional infection control measures) was observed on 11/02/15 & 11/03/15 to have a suctioning machine in their room, and a fluid collection canister was filled with yellowish liquid material. Per interview on the morning of 11/03/15 at 8:52 AM, the resident and the spouse acknowledged the filled canister and stated "this has been sitting here [for about two weeks] and we think that's disgusting". Per review of the resident's chart, the resident had not been suctioned for approximately two weeks. Per interview at 9:56 AM the Director of Housekeeper stated that nursing staff would be responsible for the suction machine canister. The Unit Nurse Manager was then made aware of the canister and the potential lack of a sanitary environment, which [he/she] confirmed.

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