

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

May 23, 2016

Ms. Jennifer Priestley, Administrator
Bennington Health & Rehab
2 Blackberry Lane
Bennington, VT 05201-2300

Dear Ms. Priestley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 2, 2016**. 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

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 C 05/02/2016
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)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 159 SS=B	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p>	F 159	<p>The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.</p> <p>Resident #1 signed agreement.</p> <p>Resident #2 provided statement of their account.</p> <p>Other residents with accounts have the potential to be affected.</p> <p>Audit will be performed to verify signed agreements have been obtained.</p>	5-27-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:

Janet Pruech

TITLE

Administrator

(X6) DATE

5/20/16

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.

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 C 05/02/2016
--	--	--	---

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 159	<p>Continued From page 1</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to have written agreement to safeguard and manage an account for the personal funds for 1 of 4 residents in the survey sample, Resident #1. The facility also failed to provide quarterly statements to 1 of 4 residents in the sample, Resident #2. The facility also failed to have personal resident funds readily accessible to residents. Findings include:</p> <p>1.) Review of agreements that the facility provides to residents for whom they manage personal funds accounts presented that one of four residents, Resident #1, did not have a signed agreement. The business office manager confirmed at 12:31 PM that the residents sign an agreement for managing of funds, but there is no evidence that Resident #1 has such a signed document. S/he further confirmed that the facility does manage the personal funds account for Resident #1.</p> <p>2.) Review of quarterly statements for the four sampled residents presented that Resident #2</p>	F 159	<p>Residents who are their own guarantor were provided statements of their accounts.</p> <p>A secure cash box is available for resident access to their funds on weekends/after hours.</p> <p>Signs are posted in Resident areas and the process was reviewed at Resident Council meeting.</p> <p>BOM responsible ED to Monitor.</p> <p><i>F159 POC accepted 5/20/16 BBorrell RN/PLM</i></p>	5-27-16
-------	--	-------	--	---------

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 C 05/02/2016
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)	(X5) COMPLETION DATE	
F 159	Continued From page 2 has quarterly statements that are sent to his/her son instead of to him/her. The resident is his/her own guarantor and there is no evidence that s/he has a financial Power of Attorney. The resident stated in an interview at 2:00 PM that s/he handles his/her own money and that his/her son is not responsible for it. The quarterly statement according to the business office manager at 12:26 PM, is not being given to the resident but is being sent to the family member. The Unit Manager confirmed at 2:23 PM that the medical record indicates that the resident is the guarantor and there is no evidence that the family member is the legal representative for finances.	F 159			
F 282 SS-G	3.) Per interview with the Business Office Manager, personal resident funds are not available after hours and on weekends. Per interview with Resident #2, s/he stated that s/he did not think they could get any money on Sundays. The facility did not have funds available upon request and had to wait for corporate to send a check for Resident #2. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide services in accordance with resident's care plan for one of one residents, Resident #3. Findings include:	F 282	1. Corrective actions for the resident found to have been affected by the alleged deficient practice: Staff were reeducated regarding Resident # 3 plan of care and services need to be provided in accordance to the plan of care. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Nursing staff education on safe resident handling policy. Residents that require assistance with transfers have a potential to be affected by the alleged deficient practice.	5-27-16	

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 C 05/02/2016
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)	(X5) COMPLETION DATE	
F 282	Continued From page 3 Per record review, Resident #3 sustained a skin tear of unknown etiology on 4/21/16. When the resident was put back to bed after lunch on 4/21/16, s/he was crying out in pain and upon exam, s/he was found to have a skin tear on the lower aspect of the right leg. The Licensed Nursing Assistant (LNA) that was responsible for the care of Resident #3 informed the nurse that the skin tear had not been present in the morning. On 4/24/16 the resident was sent to the emergency room secondary to increased pain in the right leg and upon examination of the X-ray, s/he was diagnosed with a non-displaced right tibia fracture. During the internal investigation, it was found that the LNAs that had transferred the resident from the wheelchair to bed had done so without use of a mechanical lift device as stated in the plan of care for Resident #3. A phone interview was conducted with one of the LNAs at 12:39 PM and s/he confirmed that the care plan had not been followed during the transfer of the resident and it was further confirmed by the second LNA at 12:58 PM via telephone conversation. The Director of Nursing Services (DNS) confirmed that the LNAs were suspended for failure to follow the care plan.	F 282	3. Measures/Systemic changes put into place to ensure the alleged deficient practice does not reoccur: LNA will be in-serviced by NPE/CNE/Designee on following the plan of care for transfer. 4. Corrective action will be monitored to ensure the alleged deficient practice will not reoccur: Weekly random audits will be conducted by the NPE/CNE/Designee to monitor effectiveness of the plan. Results of the audits will be reported at the QAA committee monthly for 3 months at which time the QAA committee will determine further frequency of the audits. 5. Corrective action will be completed by 5/27/2016. <i>F282 POC accepted 5/20/16 Brentell RN/ Pme</i>		
F 493 SS=C	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the	F 493			

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 C 05/02/2016
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)	(X5) COMPLETION DATE	
F 493	Continued From page 4 facility This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the governing body failed to appoint an administrator who is licensed by the State. Findings include: Per interview with acting administrator on 5/2/16 at 10:15 AM, s/he confirmed that the former administrator left their position on April 11, 2016 and s/he was to fill in as the administrator until the position could be filled. S/he said that s/he began working in the capacity of administrator the day after the former administrator vacated the position and further stated that there was an administrator in training (AIT) that would also fill in on days that s/he was not available. S/he stated that the AIT was not licensed at this time and that his/her license had lapsed and was not issued for a renewal until 4/27/16. S/he stated that they have been working at the facility 40 hours a week. Review of the administrator's license showed that it was issued April 27, 2016 and will expire May 31, 2016. Vermont Statutes, Title 18, Chapter 046: § 2060. Violations and penalties A person who practices, or offers to practice, nursing home administration in this state, without being licensed in accordance with this chapter; or any person presenting or attempting to use as his or her own the license of another; or a person who gives any false or forged evidence of any kind in attempting to obtain a license; or a person who falsely impersonates another licensee; or a person who attempts to use an expired or	F 493	Past noncompliance: no plan of correction required.		

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 C 05/02/2016
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)	(X5) COMPLETION DATE	
F 493	Continued From page 5 revoked license or any person who violates any of the provisions of this chapter, shall be subject to the penalties provided in 3 V.S.A. § 127(c). (Added 1969, No. 248 (Adj. Sess.), § 2, eff. April 1, 1970; amended 2007, No. 29, § 3.) Office of Professional Regulation Administrative Rules for Nursing Home Administrators, Effective March 15, 2009. 2.3 Administrator-in-training Program (b)(3) Supervision: The program must be completed under the supervision of a preceptor approved by the Director. "Supervision" means on-site supervision (on the premises of the facility). The supervisor must be readily available to assist and answer questions, but may be off the premises for limited periods of time for vacations, conferences, etc. but still must be available by phone, not to exceed an average of more than one day per week.	F 493			
F 497 SS=B	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	F 497	Performance reviews for the 2 LNA's were completed. An audit was performed to ensure annual LNA evaluations were completed. Missing evaluations were completed.	5-27-16	

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 C 05/02/2016
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)	(X5) COMPLETION DATE	
F 497	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to complete a performance review once every 12 months for 2 of 4 Licensed Nursing Assistants. Findings include: Review of employee records for education and required background checks presented that one Licensed Nursing Assistant (LNA) was hired in 2014 and the other in 2009. Per interview with the Director of Nursing Service (DNS), s/he confirmed at 3:50 PM that there were no annual performance evaluations completed for the two LNAs in 2015.	F 497	HR Manager to present schedule for evaluations At weekly Labor Management meeting and monitor completion of the evaluations. HR Manager to report findings of audit and progress of timely evaluation completion at monthly QA meeting for 3 months. ED to monitor. <i>F497 POC accepted Staffing BBoxell RN/PRN</i>		
F 499 SS=C	483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure that the facility had a licensed administrator on staff. Findings include: Per interview with acting administrator, at 10:15 AM, s/he confirmed that the former administrator left their position on April 11, 2016 and s/he was to fill in as the administrator until the position	F 499	Past non-compliance: no plan of correction required.		

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 C 05/02/2016
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)	(X5) COMPLETION DATE	
F 499	<p>Continued From page 7</p> <p>could be filled. S/he said that s/he began working in the capacity of administrator the day after the former administrator vacated the position and further stated that there was an administrator in training (AIT) that would also fill in on days that s/he was not available. S/he stated that the AIT was not licensed at this time and that his/her license had lapsed and was not issued for a renewal until 4/27/16. S/he stated that they have been working at the facility 40 hours a week. Review of the administrator's license showed that it was issued April 27, 2016 and will expire May 31, 2016.</p> <p>Vermont Statutes, Title 18, Chapter 046: § 2060. Violations and penalties A person who practices, or offers to practice, nursing home administration in this state, without being licensed in accordance with this chapter; or any person presenting or attempting to use as his or her own the license of another; or a person who gives any false or forged evidence of any kind in attempting to obtain a license; or a person who falsely impersonates another licensee; or a person who attempts to use an expired or revoked license or any person who violates any of the provisions of this chapter, shall be subject to the penalties provided in 3 V.S.A. § 127(c). (Added 1969, No. 248 (Adj. Sess.), § 2, eff. April 1, 1970; amended 2007, No. 29, § 3.)</p> <p>Office of Professional Regulation Administrative Rules for Nursing Home Administrators, Effective March 15, 2009. 2.3 Administrator-in-training Program (b)(3) Supervision: The program must be completed under the supervision of a preceptor approved by the Director. "Supervision" means on-site supervision (on the premises of the facility). The</p>	F 499			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FOR MEDICARE & MEDICAID SERVICES

FURKI APPROVED
OMB NO. 0938-0391

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 C 05/02/2016
--	--	--	---

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 499	Continued From page 8 supervisor must be readily available to assist and answer questions, but may be off the premises for limited periods of time for vacations, conferences, etc. but still must be available by phone, not to exceed an average of more than one day per week.	F 499		
-------	--	-------	--	--