

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

October 2, 2014

Ms. Suzanne Anair, Administrator  
Centers For Living And Rehab  
160 Hospital Drive  
Bennington, VT 05201-2279

Dear Ms. Anair:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 15, 2014**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

PC:kc



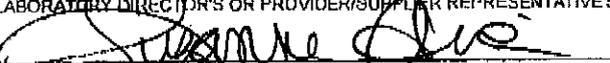
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475029</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>09/15/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CENTERS FOR LIVING AND REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 HOSPITAL DRIVE BENNINGTON, VT 05201</b>
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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
{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced on-site follow up survey for 7/14/14 was conducted by the Division of Licensing and Protection on 9/15/14. There were findings with this follow up survey.</p> <p><b>{F 280} 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</b></p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to review and revise the plan of care regarding pressure ulcers for 2 of 6 residents in the sample, Resident #1 and #2. Findings include:</p>	{F 000}	<p>The facility submits the following information and corrective action plans to demonstrate the Facility's compliance with all rules and regulation. This Plan of Correction is filed to comply with requirements set forth by CMS and does not constitute an admission that the alleged deficiencies did in fact exist</p> <p><b>F Tag 280</b></p> <ol style="list-style-type: none"> <li><b>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b>  Care plans for resident #1 and #2 have been reviewed and appropriate revisions have been made.</li> <li><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b>  All residents that are currently being treated for wounds have had a CP review and revisions have been made accordingly.</li> <li><b>What measures will be put into place or what systematic change will you make to ensure that the deficient practice does not reoccur?</b>  All new admissions and readmissions will be reviewed by a member of the nursing</li> </ol>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>09/26/2014</b>
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Any deficiency statement finding 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 280}	<p>Continued From page 1</p> <p>1. Resident #1 was admitted to the facility on 9/4/14 after an acute hospital stay for pneumonia. Resident #1 had pressure ulcerations prior to discharge from the facility to the hospital of right medial leg and upon return to the facility h/she was assessed to have Stage 1 pressure ulceration of left/right buttock. Treatment was for barrier cream and prevention was to turn/position and perform routine skin assessments. Care plan was not revised until 9/12/14 to reflect changes and to introduce interventions for the pressure area. Confirmation was made at 1:40 PM by the Director of Nursing (DON) that there is no evidence that the care plan had been revised to include the pressure area on the buttocks.</p> <p>2. Resident #2 was readmitted to the facility on 9/4/14 after an acute hospital stay for cardiac related problems. Upon readmission to the facility Resident #2 was assessed on 9/10/14 to have stage 2 pressure areas on right and left buttock measuring as 4.0 x 4.5cm with depth of less than 0.1cm on the right buttock and on the left buttock a Stage 2 measuring in size as 1.7 x 0.7cm that is improving. There is no evidence that a care plan revision was made to include the pressure ulcers of the buttocks. Confirmation was made by the DON at 1:40 PM that there is no evidence that a care plan had been revised to include the pressure areas on the buttocks.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced</p>	{F 280}	<p>leadership team within 24 hours of admission/readmission.</p> <p>All care plans of residents with wounds will be reviewed at the weekly "At Risk" meeting.</p> <p>4. <i>How will the corrective action be monitored to ensure the deficient practice does not reoccur, i.e.; what quality assurance program will be put into place?</i></p> <p>All care plans of residents with wounds will be monitored 5 out of 7 days of every week for the next 4 weeks, then weekly for 4 weeks. Thereafter random reviews will be done monthly for 3 months.</p> <p>5. <i>Date corrective action will be complete:</i> October 3, 2014 F380 POC accepted 9/30/14 B Borker RAJ/pmc</p> <p><b>F Tag 281</b></p> <p>1. <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Resident #1's wound was resolved—no further action is indicated.</p> <p>2. <i>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</i></p>	
F 281 SS=D		F 281		

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F 281	<p>Continued From page 2</p> <p>by: Based on record review and staff interview the facility failed to meet professional standards of quality for 1 of 3 residents reviewed in the sample, Resident #1. Findings include:</p> <p>During record review of physician orders for wound care for Resident #1, it was noted that the physician, on 9/7/14, ordered Xerofoam, 2X2 gauze and tegaderm as the treatment for a wound on the right buttock. Review of the treatment record presents that the nursing staff have been utilizing Normal Saline, hydrogel and aquacel foam and a kling. Confirmation was made by the Director of Nursing at 2:40 PM that the nursing staff have not been following the physician orders.</p> <p>Reference based on Standards of Professional Nursing Practice, Lippincott manual of Nursing Practice 19th edition, Wolthers Kluwer Health/Lippincott Williams, Page 17, Standards of practice was deviated with the failure to follow physician orders.</p>	F 281	<p>100% of all residents were assessed for wounds. 100% of all MD orders regarding skin treatments were reviewed and reconciled with existing wounds. The following policies were reviewed and updated accordingly: Transcription of Physician's Orders, Physician's Orders, MAR/TAR Guidelines for Use.</p> <p>3. <i>What measures will be put into place or what systematic change will you make to ensure that the deficient practice does not reoccur?</i></p> <p>All nurses were educated on the transcription process and the process for conducting 24 hour chart checks.</p> <p>4. <i>How will the corrective action be monitored to ensure the deficient practice does not reoccur, i.e.; what quality assurance program will be put into place?</i></p>	
F 314 SS=E	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p>	F 314	<p>Random 24 hour chart checks will be audited 5 out of 7 days for the next 4 weeks, then weekly times 4 weeks, then monthly for 3 months.</p> <p>5. <i>Date corrective action will be complete:</i> October 3, 2014</p> <p><i>F281 POC accepted 9/30/14 BOSTERMAN/AMC</i></p>	

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F 314	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to assure residents with pressure sores receive the necessary treatment to promote healing, prevent infection and prevent new sores from developing for 3 of 3 residents in the sample. (Residents #1, 2, 3)</p> <p>1. Resident #1 was admitted to the facility 9/4/14 after an acute hospital stay for pneumonia. Prior to hospitalization, Resident #1 presented with wounds to lower right medial leg and the wound was assessed and treated per orders. When returned from the hospital h/she was assessed, and documentation presented that the resident had a Stage 1 pressure area on his/her right/left buttock. Treatment was barrier cream and prevention strategies were to turn/position the resident and perform routine skin care assessments. Per review of the treatment record (TAR), there is no evidence that the barrier cream was applied and it was not on the TAR. On 9/7/14, wound documentation presents that there is a Stage 2 pressure area on the right inner ankle. A later entry on the same day states that the right medial leg is a current Stage 2 and status is improving. There is no documentation mentioning the buttocks for measurements or assessment. A 9/10/14 entry also does not address the buttock areas, nor is there evidence in other documentation to support that the facility assessed the buttocks areas present on admission. At 12:23 PM the Director of Nurses (DON) confirmed that the documentation doesn't provide the information as to what area the resident had and which areas were measured, also that the buttocks has not been resolved and that it is no longer being monitored.</p>	F 314	<p><b>F Tag 314</b></p> <p>1. <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Resident #1's wounds have resolved---no further interventions are indicated. Residents #2 and #3 received a full skin assessment and documentation of the assessment reflected accurate documentation of wound sites and condition.</p> <p>2. <i>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</i></p> <p>100% of all residents were assessed for wounds. 100% of all MD orders regarding skin treatments were reviewed and reconciled with existing wounds.</p> <p>3. <i>What measures will be put into place or what systematic change will you make to ensure that the deficient practice does not reoccur?</i></p> <p>All residents with wounds will be reviewed at the weekly "At Risk" meeting. 100% of all nurses were educated on skin/wound documentation.</p>		

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F 314	Continued From page 4  During record review of physician orders for wound care for Resident #1, it was noted that the physician, on 9/7/14, ordered Xerofoam, 2X2 gauze and tegaderm as the treatment for a wound on the right buttock. Review of the treatment record presents that the nursing staff have been utilizing Normal Saline, hydrogel and aquacel foam and a kling. Confirmation was made by the Director of Nursing at 2:40 PM that the nursing staff have not been following the physician orders.  2. Resident #2 was admitted to the facility on 8/27/14 and it was documented that h/she had Stage 2 pressure ulcers of the left and right buttock. Wound #1 was the left upper buttock and measured 5.5 x 6.5cm and that Wound #2 was of the right upper buttock and measured 0.4 x 0.6cm. Per interview with the DON at 12:23 PM, h/she stated that the documentation was inaccurate as the wounds were red and not blanchable and that they were actually Stage 1 areas and that an area is not a Stage 2 until the skin has is no longer intact. An entry on 9/3/14 presents that an area was noted on the left heel to be brown in discoloration and measured as 2.0 cm in diameter and is indicated to be a Stage 1. There are no further measurements of the left heel. 9/10/14 wound documentation presents the site as the left and right buttocks and as a Stage 2. Measurements of the right buttock on 8/27 were 0.4 x 0.6cm. There were no measurements on 9/3/14 and on 9/10 the area measured 4.0 x 4.5cm and was listed as improved. The DON confirmed at 1:40 PM that the measurements were inaccurate and the areas that were measured did not illustrate where the wounds were.	F 314	4. <i>How will the corrective action be monitored to ensure the deficient practice does not reoccur, i.e.; what quality assurance program will be put into place?</i>  All documentation of wounds and wound care will be monitored 5 out of 7 days of every week for the next 4 weeks, then weekly for 4 weeks. Thereafter random reviews will be done monthly for 3 months.  5. <i>Date corrective action will be complete:</i> October 3, 2014.  F314 POC accepted 9/30/14 BBoone/PMU	

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F 314	Continued From page 5  3. Resident #3 was admitted to the facility 8/16/14 and upon admission was assessed to have a Stage 2 on right buttock measuring 4.5 x 2.5cm. Entry on 8/28/14 indicated no measurements, and there were no measurements for 9/3, 9/6 or 9/10/14. Documentation indicates that the area is improving. Documentation on 8/27 presents that resident has area on lower right buttock and on 8/28 it states that the area is on the sacrum/coccyx. An entry in the record then presents that on 8/29 the coccyx was without an open area, but a Stage 2 is present, but no indications as to whereabouts or size of the wound. 1:40 PM per confirmation from the DON, there is no evidence that the wound was assessed and there is no evidence of where the wound is.	F 314			