



AGENCY OF HUMAN SERVICES  
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING  
Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 241-2345  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 241-2358

November 6, 2009

Susan Kane, Administrator  
Centers For Living And Rehab  
160 Hospital Drive  
Bennington, VT 05201

Provider #: 475029

Dear Ms. Kane:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 22, 2009**. Please post this document in a prominent place in your facility.

We will 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,

Suzanne Leavitt, RN, MS  
Licensing Chief

Enclosure



PRINTED: 10/27/2009  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/22/2009
NAME OF PROVIDER OR SUPPLIER  CENTERS FOR LIVING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 160 HOSPITAL DRIVE 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	RESIDENT #326		
F 279 SS=D	<p>An annual recertification survey was conducted from October 19, 2009 through October 22, 2009.</p> <p>483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a comprehensive care plan for 2 applicable residents in the sample. (Residents # 146 and #326) Findings include:</p> <p>1. Per record review on 10/22/09 at 7:48 AM, there was no comprehensive care plan developed for Resident # 326 who had a stage 2 pressure ulcer. The pressure ulcer was identified on</p>	F 279	<p>Resident was admitted on 10/9/09 from acute care hospital with Stage II pressure ulcer. Initial automatic care plan was not triggered; however, on 10/9/09 resident was care planned for daily skin observations, which were documented as completed. The resident also received appropriate intervention and care for Stage II pressure ulcer per physician Standing Orders as documented by nurses. The resident was also provided with a treatment surface for pressure ulcers. As a result of these interventions, the resident's pressure ulcer improved from Stage II at admission to a Stage I on 10/21/09 and was completely resolved on 11/2/09.</p> <p>On 10/21/09 a comprehensive care plan was developed per MDS schedule and included a more specific skin integrity care plan.</p> <p>Care plans of newly admitted residents will be reviewed to verify that initial care plan has been triggered.</p> <p>Nurse care coordinators will verify automatic care plan has been triggered when completing admission diagnosis list.</p>	10/21/09 11/6/09 11/6/09	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Susan Kaw, MS, RN, NHA* TITLE *Administratrix* (X8) DATE *11/4/09*

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 279	Continued From page 1 10/9/09 during the initial nursing assessment. The Director of Nursing Services confirmed that a comprehensive care plan was not developed until 10/21/09.  2. Resident #146, a patient on the Elective Medicare Certified Hospice Program, provided through the Visiting Nurse Association of Southwest Health Care (VNA of SWHC), was admitted to the facility on 3-25-09. Per record review, there was no mention of Hospice care provided to this resident on the Resident's Comprehensive Care Plan in the Electronic Clinical System (ECS). This was confirmed through interview with the Nurse Unit Manager on the morning of 10-22-09.  F 280 SS=D 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS  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.  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.	F 279A	A weekly audit report from electronic chart system will be completed by Clinical System Specialist and reported to nurse managers and DNS. 11/13/09  DNS will report compliance with audit to Administrator and Quality/Safety committee monthly. RESIDENT #146 The Hospice plan of care interventions had been integrated into the facility's electronic charting system at admission. The Hospice Care Plan was in hardcopy in the resident's chart. The Hospice nurse & Social worker attended the resident's care plan meetings as members of the multidisciplinary team. The Hospice nurse documents in the resident's (facility's) electronic chart. A Hospice LNA provides assistance at lunchtime daily. The nurses' notes document participation and communication with the Hospice team. The resident's hard copy chart was clearly labeled "Hospice."  The care plan in the electronic chart now states Hospice. Resident is the only Hospice patient in the facility at this time. Nursing care coordinator will verify that 11/2/09

SK 11/4/09

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F 280	Continued From page 2  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to revise the care plan for eating and positioning for 1 applicable resident. (Resident #18) Findings include:  1. Per observation on 10/19/09 at 5:00 PM and on 10/20/09 at 12:07 Resident #18 was sitting in a reclining [wheel] chair, sitting arms length from the table, spilling drinks [hot chocolate] and food. When asked by the surveyor if the resident wanted to sit upright and closer the resident answered yes. Per record review on 10/21/09, a care plan dated 2005 by the Occupational Therapist directed staff to 'optimize intake [for dining]. The care plan dated 8/11/09 addressed mobility issues however did not address an eating care plan for the new chair received in May 2008. Per interview on 10/22/09 at 9:30 AM the DNS and Physical Therapist confirmed that the Care Plan does not reflect the current need for positioning during meals.	F 280	automatic Hospice care plan has been triggered at admission when completing admission diagnosis or when Hospice services are initiated. A weekly audit will be completed by Clinical System Specialist and reported to Nurse manager and DNS. DNS will report monthly to Administrator and Quality/Safety committee.  RESIDENT #18 Care plan was modified to encourage resident to allow chair to be slowly raised to highest level at meal & snack times and as close to table as possible. OT/COTA will provide meal-time dining observation to identify other potential seating improvement opportunities. Seating observation audit will be completed by OT/COTA 4 times per month and audits reported to Nurse manager & DNS. Nurse educator will provide refresher inservice on meal-time seating. Results of seating observation audit(ExhibitA) will be reported monthly to Administrator and to Qulaity/Safety committee.	11/6/09 11/13/09 11/25/09 10/22/09 11/3/09 11/13/09 11/25/09 11/25/09 11/25/09	

*DR account 11.5.09 SK 11/4/09*  
*RT mby*

EXHIBIT 'A'

CENTERS FOR LIVING AND REHABILITATION

BENNINGTON, VT

**QUALITY MONITORING TOOL  
DINING POSITIONING AUDIT**

DATE: \_\_\_/\_\_\_/\_\_\_

MEAL OBSERVED: \_\_\_\_\_

NAME OF PERSON COMPLETING AUDIT: \_\_\_\_\_

CRITERIA		YES	NO
1.	Are residents/patients in an upright seating position or as care planned during meal?		
If no, corrective action taken:			
2.	Are residents/patients close enough to the dining table to comfortably reach their meal?		
If no, corrective action taken:			
Staff Education provided:			

SK 11/4/09