

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

December 6, 2013

Mr. Alan Blier, Administrator  
Centers For Living And Rehab  
160 Hospital Drive  
Bennington, VT 05201

Dear Mr. Blier:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 6, 2013**. 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

REVISED  
11/26/13

PRINTED: 11/14/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/06/2013
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	<b>Tag F000</b> The Facility appreciates the opportunity to address the findings of the Division of Licensing and Protection survey that ended on November 8, 2013, and to submit the following information and corrective actions plans to demonstrate the Facility's compliance.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated	F 225	<b>Tag F225</b> <u>Background information:</u> Facility policy entitled "Abuse Neglect and Exploitation Prohibition" was reviewed by the surveyors and found to be in compliance with applicable regulations. However, the surveyors found that the policy was not followed by staff in the case of one resident. Upon review following the survey, improvements to the policy were identified, as was the need for re-education on the policy.  The Facility notes that the employee referenced in this tag as well as Tag F226 as being suspected of utilizing a resident's medication for personal use is no longer in the employ of the Facility.  <u>Plan for Correction:</u> All Facility residents have been identified as having the potential to be affected by the issues addressed in this Tag F225.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alan Bliss NHA TITLE: Administrator (X6) DATE: 11/26/13

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.

AMC



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  CENTERS FOR LIVING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 100 HOSPITAL DRIVE BENNINGTON, VT 05201	
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F 225	Continued From page 2	F 225	<u>Tag F225 (continued)</u>	Ongoing
F 228 SS=D	<p>Per interview with the facility Director of Nursing on 11/6/13, he/she reviewed his/her investigation and confirmed that the incident on 7/27/13 was not reported to the appropriate state agency until 8/23/13 per the date on the fax receipt and he/she confirmed that a reportable incident was to be called to the appropriate state agency within 24 hours of the incident.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The findings include:</p> <p>1. Per review on 11/6/13 of the facilities internal investigation, a facility Licensed Practical Nurse (LPN) was suspected of utilizing a resident's medication for the LPN's personal use on 7/27/13. Per review of the written statements, a facility Licensed Nursing Assistant (LNA) reported to the RN Supervisor on 7/27/13 that a facility LPN asked the LNA to apply a lidoderm patch to the LPN's back. The LNA informed his/her supervisor who was the RN Supervisor that after he/she applied the Lidoderm patch, the LNA</p>	F 226	<p>The Corporate Compliance Officer will provide monitoring of 100% of state reported events for compliance with the state law requirements in the form of a review of 100% of event reports filed in the category of "State Report Filed." This monitoring will occur weekly for 3 months to ensure compliance and will provide correction and additional education as deviations are identified. The results of this monitoring will be reported to the Executive Compliance Committee each quarter and subsequently to the Board level Audit and Compliance Committee.</p> <p><i>F225 POC accepted 12/2/13 BBohler/N/ame</i></p> <p><u>Tag F226</u></p> <p><u>Background information:</u></p> <p>Facility policy entitled "Abuse, Neglect and Exploitation Prohibition" was reviewed by the surveyors and found to be in compliance with the with applicable regulations. However, the surveyors found that the policy was not followed by staff in the case of one resident. Upon review following the survey, improvements to the policy were identified, as was the need for re-education on the policy.</p>	Ongoing

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NAME OF PROVIDER OR SUPPLIER  CENTERS FOR LIVING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 160 HOSPITAL DRIVE BENNINGTON, VT 05201	
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F 226	Continued From page 3 heard the LPN tell the resident that the LPN had "borrowed" one of the residents patches.  Per review of the fax receipt an event report was sent to the Division of Licensing and Protection (DLP) notifying the agency of the reportable event on 8/23/13.  Per review of the internal investigation and interview with the Unit Manage on 11/6/13, the RN Supervisor did not report the incident to the UM until 8/23/13 and then the Director of Nursing on 8/23/13 after the resignation of the suspected LPN was received by the facility and facility staff then reported the incident to the UM.  Per interview with the facility Director of Nursing on 11/6/13, he/she reviewed his/her investigation and confirmed that the incident on 7/27/13 was not reported to the appropriate state agency until 8/23/13 per the date on the fax receipt and he/she confirmed that a reportable incident was to be called to the appropriate state agency within 24 hours of the incident.	F 226	<u>Tag F226 (continued)</u> <u>Plan for Correction:</u>  All Facility residents have been identified as having the potential to be affected by the issues addressed in this Tag F226. To ensure the immediate safety of all Facility residents, the Medication Administration Record (MARS) and Treatment Administration Records (TARS) for all residents within the facility from September 3, 2013 to November 15, 2013 were reviewed by the Interim DNS and designees, to ensure that no medications were documented as missing. Pain assessments for all residents were also reviewed for the same time period. The review of the MARS, TARS and pain assessments for all residents was completed by November 22, 2013. No deficiencies were found.  The policy and procedures entitled "Medication Administration", "Pain Management", "Narcotic Count Sheet", and "Narcotic Administration" were reviewed. The "Pain Management" and "Medication Administration" policies were updated to provide accountability for pain medications. All non-over-the-counter pain medications were added to the shift-to-shift count to be conducted at the same time and in the same manner as the narcotic count. Education on the policy change for pain medication accountability and shift-to-shift medication count is being provided to all nursing staff and will be completed by December 2, 2013.	11/22/13
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280	The Facility's policy on "Abuse, Neglect and Exploitation Prohibition" was revised on November 20, 2013 to include the federally-mandated 24-hour timeframe for reporting to the Facility Administrator and to update the Facility reporting procedure. Education on the standards, process and expectations for reporting abuse, neglect or exploitation is being conducted for 100% of Facility staff and will be completed by December 2, 2013.	12/2/13

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F 226	Continued From page 3 heard the LPN tell the resident that the LPN had "borrowed" one of the residents patches.  Per review of the fax receipt an event report was sent to the Division of Licensing and Protection (DLP) notifying the agency of the reportable event on 8/23/13.  Per review of the internal investigation and interview with the Unit Manage on 11/6/13, the RN Supervisor did not report the incident to the UM until 8/23/13 and then the Director of Nursing on 8/23/13 after the resignation of the suspected LPN was received by the facility and facility staff then reported the incident to the UM.  Per interview with the facility Director of Nursing on 11/6/13, he/she reviewed his/her investigation and confirmed that the incident on 7/27/13 was not reported to the appropriate state agency until 8/23/13 per the date on the fax receipt and he/she confirmed that a reportable incident was to be called to the appropriate state agency within 24 hours of the incident.  Per review of the facility policy and procedure titled Abuse Neglect and Exploitation reviewed last on 12/2001, the policy indicates that every employee and volunteer is responsible to "cause a report to be made" to APS of any actual or suspicious act or sign of abuse, neglect or mistreatment. When informed, employee/volunteer must immediately reporting all such circumstances to his/her supervisor. This supervisor will proceed with the reporting process until the report is made to the Administrator or designee.	F 226	<u>Tag F226 (continued)</u>  After December 2, 2013, any staff members who have not completed these trainings will not be permitted to return to duty until they have been completed. The understanding and competency of this education will be assessed by obtaining a passing score on a written test. All new staff will complete the same course as a component of their orientation program  <u>Monitoring:</u> The DNS or designee will monitor a random sample of the count sheets daily, providing correction and additional education as needed, for a period of 4 weeks, with weekend count sheets reviewed on Mondays, and random sample on a monthly basis thereafter for 3 months, assessed by the Facility Safety-Quality committee.  In addition, the monitoring provision provided in response to Tag F225 is referenced and incorporated.  <i>F226 POC accepted 12/2/13 BBoettelRdl/pml</i>	12/2/13  Ongoing  Ongoing
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280	<u>Tag F280 (see following page)</u>	

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F 280 SS=D	<p>Continued From page 4</p> <p><b>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 record review and staff interview the facility failed to assure that the care plan was revised by qualified persons after each assessment for 1 resident of 35 sampled Stage 1 residents, Resident #41. (R#1) Findings include:</p> <p>Per record review, R#41 was assessed with a Stage 3 pressure ulcer on 12/29/12. The Impaired Skin Integrity care plan was initiated on admission in 2004. There are numerous discontinued entries on the care plan. There are no revisions to the care plan after the discovery of a Stage 3 pressure ulcer on the coccyx/R Upper</p>	F 280	<p><b>Tag F280 (continued)</b></p> <p><u>Background information:</u></p> <p>Facility policy entitled "Plan of Care" was reviewed by the surveyors and found to be in compliance with applicable regulations. However, the surveyors found that the policy was not followed by staff in the case of one resident. Upon review following the survey, improvements to the policy were identified, as was the need for re-education on the policy.</p> <p><u>Plan for Correction:</u></p> <p>All Facility residents have been identified as having the potential to be affected by the issues addressed in this Tag F280. To ensure the immediate safety of all Facility residents, a review of the treatment sheets to identify skin issues and the correlating interventions was compared to the care plans of those residents with skin issues. The review of the treatment sheets and correlating interventions compared to care plans was completed for 100% of Facility residents on November 22, 2013.</p> <p>The Facility policy entitled "Plan of Care" was revised to provide greater direction regarding need for timely updates to the Care Plan and to assign responsibility for the response to the indicated changes. Education and staff in-servicing was provided to all licensed nurses on the importance of initiating timely interventions and on the care plan process, including the step-by-step process to place the entries in the Electronic Charting System. This education included specific requirements of the revision to the policy "Plan of Care". This education and in-servicing will be completed on December 2, 2013. This education has been documented and tracked via a sign-off sheet. 100% of licensed nursing staff is required to complete this competency. After December 2, 2013, any staff member who has not completed this training will not be permitted to return to duty until the competency has been completed. The</p>	11/22/13  12/2/13

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NAME OF PROVIDER OR SUPPLIER  CENTERS FOR LIVING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 160 HOSPITAL DRIVE BENNINGTON, VT 05201	
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F 280	Continued From page 5 Buttocks of R#41. In an interview on 11/6/13 the acting Director of Nursing Services (DNS) and the Care Coordinator/MDS Coordinator (CC/MDSC) confirmed that there are no revisions to the care plan to reflect interventions for treatment of the pressure ulcer and to prevent worsening of the pressure ulcer in the care plan.	F 280	<u>Tag F280 (continued)</u> understanding and competency of this education will be assessed by obtaining a passing score on a written test.  <u>Monitoring:</u> New skin findings on all residents will be identified through the use of weekly shower day skin checks, physician treatment orders and/or the 24-hour nursing report, and will be monitored by the DNS or designee daily for care plan updates for a period of 4 weeks and weekly thereafter for 3 months and assessed by the Facility Safety-Quality committee. Education on overall skin integrity will be provided and made part of this monitoring process. <i>F280 PDC accepted 12/21/13 BBoatell RN/PMC</i>	Ongoing
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that services provided or arranged by the facility for 1 resident of 35 Stage 1 sampled residents, Resident #41 (R#41) meet professional standards of quality regarding skin assessments for residents with risk for impaired skin integrity. Findings include:  Per record review R#41 was admitted to the facility in 2004 with multiple skin issues including venous stasis ulcers of the lower extremities. R#41 did not have any identified pressure ulcers upon admission to the facility. The first notation of pressure ulcers is found in a note dated 12/23/2012 when an unstagable ulcer on the Left (L) Buttocks is noted. A note dated 12/29/2013 states that there is no area found on the L Buttock but that there is a Stage 3 pressure ulcer noted on the coccyx/Right (R) Upper Buttock.  In an interview on 11/6/13 the acting Director of	F 281	<u>Tag F281</u> <u>Background information:</u> Facility policy entitled "Skin Inspection and Monitoring" was reviewed by the surveyors and found to be in compliance with applicable rules. However, the surveyors found that the policy was not followed by staff in the case of one resident. Upon review following the survey, improvements to the policy were identified, as was the need for re-education on the policy.  <u>Plan for Correction:</u> All Facility residents have been identified as having the potential to be affected by the issues addressed in this Tag F281. To ensure the immediate safety of all Facility residents, all residents within the facility were evaluated by the Interim DNS and designees for skin conditions. Skin assessments were compared to the care plan for each resident for identified skin condition and treatment. Completion of this occurred on November 21, 2013.	11/21/13

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NAME OF PROVIDER OR SUPPLIER  CENTERS FOR LIVING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 180 HOSPITAL DRIVE BENNINGTON, VT 05201	
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F 281	Continued From page 6 Nursing Services (DNS) and the Care Coordinator/MDS Coordinator (CC/MDSC) confirmed that there is no indication in the record that the pressure area was noted to reported before it had reached Stage 3. They also both stated that they were not aware of what the frequency or circumstances were regarding skin assessments by nurses. LNAs are expected to monitor the skin and report issues during care. They are not aware of any specific process for nurses regularly assessing the skin of residents at risk for skin impairments.  In an interview on 11/8/13 at 10:30 AM the DNS stated that the facility had a wound nurse who saw residents weekly. The wound nurse moved to per diem status in October of 2012 and per the DNS' statement s/he saw residents very sporadically after that until the visits stopped entirely. The facility hired a new wound nurse approximately 3 1/2 months ago.  In an interview on 11/8/13 an LPN Medication/Treatment nurse stated that s/he assesses the resident's skin if an LNA reports an issue or if s/he is providing skin treatments.  Lippincott Nursing Manual (9th Edition) Sandra M Nettina Lippincott-Raven Publishers 4/21/2009 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 281	<b>Tag F281 (continued)</b> The Facility policies entitled "Skin Inspection and Monitoring" and "Admission of the Resident" were revised and the "Weekly Skin Inspection" form was developed which will be used for 100% of residents. These provide for an initial skin assessment within two hours of admission and include daily skin checks by the LNAs, and weekly skin checks by both the LNA and a licensed nurse, with additional checks as needed. The designated RN will be notified of skin conditions as a trigger for a formal skin assessment and completion of skin assessment documentation in ECS. Skin assessments will also be conducted on admission and with the MDS assessment schedule.  Education is being provided to all nursing staff on the "Skin Inspection and Monitoring" policy changes and use of "Weekly Skin Inspection" form. This education will be completed on December 2, 2013. This education has been documented and tracked via a sign-off sheet. 100% of licensed nursing staff is required to complete this education. After December 2, 2013, any staff member who has not completed this training will not be permitted to return to duty until the education has been completed. The understanding and competency of this education will be assessed by obtaining a passing score on a written test.	12/2/13
F 314 SS=G	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	F 314	Use of the "Weekly Skin Inspection" form for all residents will begin upon completion of staff education and will be used each week for regular skin checks.	Ongoing









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F 441	<p>Continued From page 10</p> <p>Per interview on 11/5/13 with one of the unit Licensed Practical Nurse (LPN#1), he/she confirmed that the cannulas on two of the wheelchairs were not in use and were not covered and laying on the cushion in the seat of the wheelchairs. The LPN confirmed that this was not an appropriate way to store cannulas not in use and it does not adhere to proper infection control standards. Per interview with the Licensed Nursing Assistant (LNA) on 11/5/13, he/she indicated that nasal cannulas that were not in use by a resident could be laid uncovered on the seat of a wheelchair but it depended on how often the wheelchair seat was cleaned.</p> <p>Per interview on 11/5/13 with LPN at 3 PM, he/she confirmed that a nasal cannula for one wheelchair was not in use and was laying on the cushion in the seat of one wheelchair. LPN #2 confirmed that was not an appropriate way to store a nasal cannula when not in use and did not adhere to proper infection control standards.</p> <p>Per interview with the Unit Manager on 11/5/13, he/she observed the wheelchairs in the hallway on Frost. The UM confirmed that the wheelchairs had an O2 canister attached to the wheelchair and attached to the O2 canister was an attached nasal cannula. It was observed by the UM that the nasal cannulas were not covered and that the cannulas were laying on the cushion in the seat of each wheelchair. The UM indicated that he/she was not aware if that was an appropriate way to store a nasal cannula that was not in use by a resident.</p> <p>Per interview with the Infection Control Nurse via telephone on 11/5/13, he/she confirmed that</p>	F 441		

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F 441	<p>Continued From page 11</p> <p>having an uncovered nasal cannula laying in the cushion of the seat of a wheelchair was not within acceptable infection control standards. Per interview with the infection Control nurse on 11/5 and again on 11/6/13, he/she indicated that since his/her appointment as the Infection Control nurse, the facility focus on Infection Control has been on the immediate infections with the residents and not on education and surveillance of Infection control practices with the staff. The Infection Control nurse indicated that he/she had not done any education with facility staff regarding infection control standards since his/her appointment. Per interview the Infection Control nurse confirmed that the staff understanding of appropriate infection control standards was not clear.</p> <p>Per interview with the facility Staff Educator on 11/6/13, he/she confirmed that outside of the mandatory yearly in-service of staff regarding infection control standards, and education upon hire there was no other education provided to the facility staff. The Staff Educator confirmed that the facility focus for infection control practices prior to the appointment of the current Infection Control nurse was addressing the immediate infections of the residents and not on education and surveillance of infection control practices with all staff. The Staff Educator reviewed the education for infection control standards for staff and confirmed that it was last reviewed with all staff last year as required and upon hire of new employees. Per interview the Staff Educator he/she confirmed that the staff understanding of appropriate infection control standards was not clear.</p> <p>Per review of the documentation provided by the</p>	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 11/14/2013  
FORM APPROVED  
OMB NO. 0938-0391

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  11/06/2013
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 441	Continued From page 12 facility there was no evidence that the facility was conducting surveillance activities to monitor infection control practices on an ongoing basis to prevent the transmission of disease and infection.  Per review of the facility policy and procedure titled "Infection Control Standards" last revised on 10/10, the policy and procedure indicates under the Responsibilities, the policy and procedure indicates that the Infection Control Program is responsible for the "surveillance, prevention and control of all infection." The policy also indicates that the goal is to maintain a program in infection control that ensures employees, physicians, volunteers and others as appropriate are knowledgeable in practices necessary to perform their jobs safely.	F 441		