

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

March 23, 2012

Mr. Bruce Bodemer, Administrator
Centers For Living And Rehab
160 Hospital Drive
Bennington, VT 05201

Provider #: 475029

Dear Mr. Bodemer:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **March 1, 2012**. 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, MS
Licensing Chief

PC:ne

Enclosure



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

RECEIVED
Division of
MAR 19 12
licensing and Protection
PRINTED: 03/12/2012
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 C 03/01/2012
--	---	--	---

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		
F 282 SS=D	<p>An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection and completed on 03/01/12. The following are regulatory findings.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure that services were provided according to one applicable resident's written plan of care for transfers. (Resident #1) Findings include:</p> <p>1. Per record review on 02/29/12 Resident #1's care plan directed staff to use a hooyer lift (a mechanical lift) for transfers out of bed to the wheelchair, as this resident is unable to ambulate nor bear weight using his/her legs. Per review of the Summary of Investigation, on 02/08/12 in the morning, 2 LNAs (Licensed Nursing Assistants) assisted Resident #1 to the wheelchair by 'bodily' lifting the resident. Per review of a written statement by LNA #1, s/he reported "everyone does the 2 person lift [indicating staff were not using a hooyer lift]". Per telephone interview on 03/01/12 at 11:15 AM, LNA #2 stated "occasionally staff will transfer without the lift, there was no hooyer available at the time plus the resident wanted to get to breakfast right then".</p>	F 282	<p>F282 - Resident #1 care plan reviewed and transfer status remains appropriate. 3/16/12</p> <p>Care plans reviewed for residents with total lift devices. 3/16/12</p> <p>Staff Education Coordinator will provide re-education to LNAs regarding the use of total lift devices. 3/30/12</p> <p>Staff Education Coordinator will provide resource booklets for nursing units related to total lift devices. 3/30/12</p> <p>Random visual observation audit of transfers will be performed by nurse manager/charge nurse on each unit monthly to ensure resident is being transferred per plan of care. A copy will be given to DNS monthly, who will report at the monthly Safety-Quality Committee meeting for 3 months. 3/30/12</p> <p>G-282 POC accepted 3/22/12 Susan L. Emmerson RN</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sue Bolmer</i>	TITLE INTERIM ADMINISTRATOR	(X6) DATE 3/15/12
--	---------------------------------------	-----------------------------

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.

pmc

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

PRINTED: 03/12/2012
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 C 03/01/2012
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 282	Continued From page 1 The Director of Nursing confirmed on 03/01/12 at 11:45 AM that the services were not implemented per the care plan.	F 282		
F9999	FINAL OBSERVATIONS Per the Vermont Licensing and Operating Rules for Nursing Homes December 15, 2001, the facility failed to meet the requirement of 10.7 Proficiency of Nurse Aides, which states: "The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments and described in the plan of care." Findings include: Based on record review and interview, the facility failed to ensure that 2 applicable Licensed Nursing Assistants (LNAs) demonstrated competency skills and techniques necessary to care for residents needs. Per review of in-service files on the afternoon of 02/29/12, the facility's Staff Development Coordinator (SDC) was unable to provide evidence of annual competency reviews for 2 LNAs who had been employed for greater than 1 year. In addition, LNA #2 who was hired in March 2010, did not have observations of competencies by a Nurse during the orientation per the 'CLR-LNA Orientation checklist' dated 03/03/10. Per interview, the SDC stated that s/he was not aware if LNAs have done competencies prior to his/her hire 7 months ago, but the LNAs are expected to demonstrate competencies to a nurse during orientation. The Acting Administrator confirmed on 02/29/12 at 1:00 PM the facility "is working on the annual competency and will be done this April" and	F9999	Staff Education Coordinator will provide re-education to LNAs regarding use of total lift devices. Staff Education Coordinator has an LNA Skills Fair established for designated dates in April. Coordinator is aware that this will be incorporated annually with competencies. All Skill Fair days will be completed by 4/26/12. <i>F9999 POC accepted 3/22/12 Susan J. Emmons</i>	3/30/12 3/14/12 4/26/12

BB 3/15/12

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

PRINTED: 03/12/2012
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 C 03/01/2012
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	
F9999	Continued From page 2 confirmed the competencies were not demonstrated for the past year.	F9999			

BB

3/15/12