

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

August 31, 2012

Ms. Penny Bruso, Administrator
Centers For Living And Rehab
160 Hospital Drive
Bennington, VT 05201

Provider #: 475029

Dear Ms. Bruso:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **August 2, 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
Licensing Chief

PC:ne

Enclosure



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

PRINTED: 08/09/2012
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 08/02/2012
--	--	--	---

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 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's</p>	<p>F 157</p> <p>F157: <u>Corrective Action:</u> Resident #1 no longer resides in the facility.</p> <p><u>Other Residents:</u> All residents are at risk.</p> <p><u>Systemic Changes:</u></p> <ol style="list-style-type: none"> 1. Education provided to RN/LPNs by Staff Educator/designee regarding change in condition policy and MD/Family notification. 2. Education provided to shift supervisors and managers by the Staff Educator/designee on acute condition report and their role in follow-up with charge nurses verifying MD/Family notification when needed. <p><u>On going Monitoring:</u> DNS/designee will review 24 hr acute condition report for documentation of MD/Family notification daily x 2wks, then weekly x4, then monthly x3. DNS will report monthly to the Quality Safety Committee meeting x5 months. (Exhibit A)</p> <p>F157 Poc accepted 8/30/12 DChittenden RML PMK</p>	<p>6/11/12</p> <p>9/2/12</p> <p>9/2/12</p> <p>9/2/12</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Lenny Poma PHA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/27/12</i>
--	-------------------------------	-----------------------------

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.

PMK

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

PRINTED: 08/09/2012
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 08/02/2012
--	--	--	---

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 157	<p>Continued From page 1 legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the physician in a change of condition for 1 patient in the applicable sample. (Patient # 1) Findings include:</p> <p>Per review of nursing documentation for Resident #1 on the evening shift of 6/10/12 at 21:17 (9:17 P.M.), the staff nurse documents for Resident #1's 'sensory assessment' under the heading nose/sinuses: 'Bleeding, x 3 this shift.' There was no further documentation related to the bleeding including follow-up monitoring and/or observation on his/her shift. In addition, the staff nurse failed to communicate this change in the resident's condition to the physician and confirmed s/he was aware that the resident was on long-term anticoagulant therapy and that bleeding was a side effect.</p> <p>The next morning, on 6/11/12 at 7:40 AM the ambulance was called to transport Resident #1 to the Emergency Department because of a nosebleed. At 14:02 (2:02 P.M.) the staff nurse documents: 'Resident sent to ER per MD re nose bleed profuse and unable to stop and respirations very moist at 0730. Resident returned at 11:50 nose bleeding again and returned to ER where [s/he] was admitted.' Per interview with the staff nurse responsible for caring for Resident #1 during the evening of 6/10/12, s/he confirmed on 6/19/12 at 4:15 P.M. that the physician had not been called to report the resident's three nosebleeds although s/he was aware that the</p>	F 157		

PB 8/27/12

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

PRINTED: 08/09/2012
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 08/02/2012
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 157	Continued From page 2 resident had been on long-term anti-coagulant therapy and that bleeding is a side effect of anti-coagulant therapy.*	F 157		
F 281 SS=D	*Mosby's Nursing Drug Reference, 2012. Page 10&11. Coumadin: Assess for bleeding gums, petechiae, ecchymosis, hematuria. Report signs of bleeding: gums, under skin, urine and stools. 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, facility staff failed to provide services that met professional standards of quality for 1 resident in the applicable sample by failing to notify a physician of a change in a resident's condition. (Resident #1) Findings include: Per review of nursing documentation for Resident #1 on the evening shift of 6/10/12 at 21:17 (9:17 P.M.), the staff nurse documents for Resident #1's 'sensory assessment' under the heading nose/sinuses: 'Bleeding, x 3 this shift.' There was no further documentation related to the bleeding including follow-up monitoring and/or observation on his/her shift. In addition, the staff nurse failed to communicate this change in the resident's condition to the physician and confirmed s/he was aware that the resident was on long-term anticoagulant therapy and that bleeding was a side effect.	F 281	<u>F281:</u> <u>Corrective Action:</u> Resident #1 no longer resident in the facility. Anticoagulation policy was reviewed. All residents in facility receiving anticoagulants had care plan reviewed and arc in place. <u>Other Residents:</u> All residents receiving anticoagulants arc at risk. All residents receiving anticoagulants were identified by their current Medication Administration Record (MAR). <u>Systemic Changes:</u> 1. Monitoring of potential complications will be signed by nursing on their treatment sheet each shift. 2. Electronic charting system changed in circulatory folder to include monitoring of bleeding/bruising. 3. Education for RN/LPNs on potential complications of anticoagulant therapy implemented by Staff Educator/designee. <u>On going Monitoring:</u> Treatment sheet documentation will be reviewed weekly by Clinical Systems Specialist/designee. Weekly report will be given to the DNS. DNS will report out monthly to Quality/Safety Committee for 3 months. (Exhibit B)	6/11/12 8/23/12 8/23/12 8/23/12 9/2/12 9/2/12 9/2/12 9/2/12

PB
8/10/12

F281 POC accepted 8/30/12
DChittenden/PMC

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

PRINTED: 08/09/2012
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 08/02/2012
--	--	--	---

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 281	<p>Continued From page 3</p> <p>The next morning, on 8/11/12 at 7:40 AM the ambulance was called to transport Resident #1 to the Emergency Department because of a nosebleed. At 14:02 (2:02 P.M.) the staff nurse documents: 'Resident sent to ER per MD re nose bleed profuse and unable to stop and respirations very moist at 0730. Resident returned at 11:50 nose bleeding again and returned to ER where [s/he] was admitted.' Per interview with the staff nurse responsible for caring for Resident #1 during the evening of 8/10/12, s/he confirmed on 8/19/12 at 4:15 P.M. that the physician had not been called to report the resident's three nosebleeds although s/he was aware that the resident had been on long-term anti-coagulant therapy and that bleeding is a side effect of anti-coagulant therapy.*</p> <p>*Mosby's Nursing Drug Reference, 2012. Page 10&11. Coumadin: Assess for bleeding gums, petechiae, ecchymosis, hematuria. Report signs of bleeding: gums, under skin, urine and stools.</p> <p>*Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins, pg 17.</p>	F 281	<p><u>F281:</u> <u>Corrective Action:</u> Resident #1 no longer resides in the facility. 6/11/12</p> <p><u>Other Residents:</u> All residents are at risk.</p> <p><u>Systemic Changes:</u></p> <ol style="list-style-type: none"> 1. Education provided to RN/LPNs by Staff Educator/designee regarding change in condition policy and MD/Family notification. 9/2/12 2. Education provided to shift supervisors and managers by the Staff Educator/designee on acute condition report and their role in follow-up with charge nurses verifying MD/Family notification when needed. 9/2/12 	
F 282 SS=D	<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 staff interview and record review, the</p>	F 282	<p><u>On going Monitoring:</u> DNS/designee will review 24 hr acute condition report for documentation of MD/Family notification daily x 2wks, then weekly x4, then monthly x3, DNS will report monthly to the Quality Safety Committee meeting x5 months. (Exhibit A)</p> <p>F282 POC accepted 8/30/12 DCH/Henderson/AME</p>	9/2/12

PB
8/27/12

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

PRINTED: 08/09/2012
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 08/02/2012
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	<p>Continued From page 4</p> <p>facility failed to have services provided by qualified persons in accordance with the written plan of care for 1 resident (Resident #1) in the applicable sample. Findings include:</p> <p>Per review of nursing documentation for Resident #1 on the evening shift of 6/10/12 at 21:17 (9:17 P.M.), the staff nurse documents for Resident #1's 'sensory assessment' under the heading nose/sinuses: 'Bleeding, x 3 this shift.' There was no further documentation related to the bleeding including follow-up monitoring and/or observation during the staff nurse's shift. In addition, the nurse failed to communicate this change in the resident's condition to the physician and confirmed s/he was aware that the resident was on long-term anticoagulant therapy and that bleeding is a side effect.</p> <p>The next morning, on 6/11/12 at 7:40 AM the ambulance was called to transport Resident #1 to the Emergency Department because of a nosebleed. At 14:02 (2:02 P.M.) the staff nurse documents, 'Resident sent to ER per MD re nose bleed profuse and unable to stop and respirations very moist at 0730. Resident returned at 11:50 (A.M.) nose bleeding again and returned to ER where [s/he] was admitted.' Per review of the comprehensive care plans on 6/19/12 at 4:15 PM with the staff nurse responsible for caring for Resident #1 on the evening of 6/10/12, s/he confirmed that there was a care plan related to monitoring for any bleeding related to anticoagulant therapy.</p>	F 282			

PB
8/8-7/12

Centers for Living and Rehabilitation
Performance Improvement Audit

Exhibit A

Standard of Practice: Acute Condition Report Review

Date: _____

Number of Residents Identified _____ Reviewer: _____
on Acute Condition Report: _____

#	CRITERIA	YES	NO
1.	Was MD/Family notified appropriately? If no, see below.		
	Number of Residents needing action items:		
	Corrective Action:		
	Resident Name: _____	Action taken: _____	

This will be monitoring by exception.

Goal = 0 residents identified on the Acute Condition Report

Numerator # of residents meeting standard to notify MD/Family in change of condition

Denominator # of residents who have a change in condition

**Centers for Living and Rehabilitation
Performance Improvement Audit**

Exhibit B

Standard of Practice: Anticoagulant Treatment

Date: _____

Number of Residents on _____

Reviewer: _____

Anticoagulant Therapy: _____

#	CRITERIA	YES	NO
1.	For each resident on anticoagulant therapy were all 3 shifts signed on the treatment for monitoring of anticoagulant adverse effects? If no, see below.		
2.	For each resident on anticoagulant therapy did all 3 shifts document the monitoring of potential effects either no adverse effect of anticoagulant or bleeding/bruising documented? If no, see below.		
Corrective Action:			
	<u>Resident Name:</u>	<u>Action taken:</u>	

1. First Goal – 100% of all residents on anticoagulant had treatment sheet signed for all 3 shifts.
 - a. Numerator = # of residents on anticoagulant therapy with all 3 shifts signed
 - b. Denominator = # of residents on anticoagulant therapy
2. Second Goal – 100% of all residents on anticoagulant therapy documented the monitoring of potential adverse effects.
 - a. Numerator = # of residents on anticoagulant therapy had all documented potential adverse effects completed
 - b. Denominator = # of residents on anticoagulant therapy