

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 19, 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 **July 21, 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:jl



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

PRINTED: 08/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

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|--|---|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>475029 | (X2) MULTIPLE CONSTRUCTION:<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br>C<br>07/21/2014 |
| NAME OF PROVIDER OR SUPPLIER<br><br>CENTERS FOR LIVING AND REHAB |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>180 HOSPITAL DRIVE<br>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 279<br>SS=D  | <p>An unannounced, on-site investigation of a complaint was conducted by the Division of Licensing &amp; Protection on 7/21/2014. The following regulatory deficiencies were identified during the investigation:</p> <p>483.20(d), 483.20(k)(1) DEVELOP 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:<br/>Based on record review and staff interview the facility failed to assure that a comprehensive care plan was developed for one resident in a sample of 3, Resident #1 (R#1) who had chronic pain. Findings include:</p> | F 279  | <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><u>F Tng 279</u></p> <ol style="list-style-type: none"> <li><i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i><br/>Resident #1 was transferred to an acute care facility and did not return to this facility. Corrective action for this resident is not indicated.</li> <li><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><br/>100% of residents' care plans were reviewed to confirm that an "alteration in comfort, pain" or "potential for alteration in comfort" care plan had been established and initiated, identifying measures for ongoing pain evaluation and treatment for all residents within the facility.<br/><br/>"Plan of Care" policy was reviewed and/or revised.</li> <li><i>What measures will be put into place or what systematic change will you make to</i></li> </ol> |   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Administrator (X6) DATE 08/15/2014

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.

*ensure that the deficient practice does not reoccur?*

Routine pain evaluations were added to the MAR (medication administration record).

Education was provided to all RN's and LPN's on the initiation and development of an "Alteration in comfort, pain" or "Potential for alteration in comfort" care plan for all new and readmissions to the facility.

Education was provided to all RN's and LPN's on the "Plan of Care" policy.

**4. 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?**

For the next four weeks, the DNS and/or designee will conduct a weekly random chart audit to verify that new and readmission care plans incorporate "alteration in comfort" or "potential for alteration in comfort", followed by random monthly chart audits for three months.

ACCEPTED  
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New admissions and residents with chronic pain will be reviewed at the "At Risk" interdisciplinary team meeting to identify non-pharmacological pain interventions to be incorporated in the care plan. Incorporation of these interventions will be audited randomly on a weekly basis by the DNS and/or designee for four weeks, then monthly for three months.

**5. Date corrective action will be complete:**  
August 21, 2014

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| NAME OF PROVIDER OR SUPPLIER<br><br>CENTERS FOR LIVING AND REHAB |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>160 HOSPITAL DRIVE<br>BENNINGTON, VT 05201  |                      |   |
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| F 279  | Continued From page 1  | F 279  |  |                      |   |
| F 280<br>SS=D  | <p>Per review of the record on 7/21/14 at 1 PM, R#1 had a diagnosis of Esophageal Cancer with Metastases and was recovering from fractures of his Femur and a Thoracic Vertebrae. In a review of pain assessments, the resident received regular doses of "as needed" pain medication daily for pain levels reported in the 6 to 10 range, on a scale of 10. There is no Alteration in Comfort or Pain related care plan for the resident. In interviews on 7/21/14 at 3:45 PM the Director of Nurses (DNS) confirmed that there was no care plan for pain.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</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> | F 280  | <p><b>F Tag 280</b></p> <ol style="list-style-type: none"> <li><i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i><br/>Resident #1 was transferred to an acute care facility and did not return to this facility. Corrective action for this resident is not indicated.</li> <li><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><br/>The care plans of all residents were reviewed for hydration and self-care deficit interventions and updated as needed.</li> <li><i>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not reoccur?</i><br/>The facility policies "Plan of Care" and the "24 Hour Census and Acute Condition Report" were reviewed and/or revised.<br/><br/>Education was provided to all nurses regarding policy changes to include identification, initiation, and communication of care plan changes indicated with changes in resident condition/self-care abilities.</li> </ol> |                      |   |

Residents with changes in condition will be reported to the supervisor and placed on the 24 hour report. The oncoming supervisor will audit care plan changes for identified residents with change in condition.

The "24 hour report form" was expanded to improve communication and documentation for follow-up.

Residents with changes in condition will be reviewed at the weekly interdisciplinary team meeting with care plan review to be conducted by the team members.

**4. How will the corrective actions be monitored to ensure the deficient practice will not reoccur, i.e.; what quality assurance program will be put into place?**

For the next four weeks, the DNS and/or designee will conduct a weekly random chart audit to verify that residents' care plans are updated to address changes in resident status/self-care abilities, with monthly random chart audits for three months thereafter. Results of these audits will be reported out at the monthly Quality-Safety Committee meeting.

ACCEPTED  
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**5. The dates corrective action will be completed:**

August 21, 2014

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| F 280  | Continued From page 2<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to assure that the comprehensive care plan was revised for one resident in a sample of 3, R#1. Findings include:<br><br>Per record review on 7/21/14, R#1 had a fractured Left Humerus (arm). His left arm was his dominant arm. There were no revisions to the ADL Self-Deficit care plan or the Nutrition care plan to indicate the resident's change in ability to drink without assistance and the need for fluid assistance throughout the day. The DNS confirmed in an interview at 4:20 PM that there was no revision of the care plan to reflect the resident's change in ability to hydrate. | F 280  | <u>F Tag 282</u><br>1. <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i><br>Resident #1 was transferred to an acute care facility and did not return to this facility. Corrective action for this resident is not indicated.  |   |
| F 282<br>SS=D  | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to assure that services were provided in accordance with the residents written plan of care for one resident in a sample of three, R#1. Findings include:<br><br>Per record review R#1 was admitted to the facility with pressure ulcers on his Left and Right Buttocks. Additionally two other pressure areas on the Right and Left Buttocks developed after                                      | F 282  | 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><br>100% of treatment records were reviewed and compared to skin documentation to correlate skin conditions/wounds with an identified treatment.<br><br>3. <i>What measures will be put into place or what systemic changes will you make to insure that the deficient practice does not reoccur?</i><br>Treatment records will be generated by the pharmacy.<br><br>All RN's and LPN's were educated on wound care prevention and documentation, including routine monitoring of wound appearance during regular and as needed dressing changes. |   |

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| F 282  | Continued From page 3<br>admission to the facility. There is no evidence in the record of the consistent treatment of the right Buttock pressure areas. The DNS confirmed in an interview on 7/21/14 that there is not documentation of consistent daily wound care of the Right side pressure areas. | F 282  | <p>4. <i>How will the corrective actions be monitored to insure the deficient practice will not recur, i.e.; what quality assurance program will be put into place?</i><br/>The DNS and/or designee will perform random audits of skin care documentation weekly for four weeks, then monthly thereafter for three months.</p> <p>5. <i>The date corrective action will be completed.</i><br/>August 21, 2014.</p> <p style="text-align: center;"><i>POC<br/>ACCEPTED<br/>Mdygmo RN</i></p> |                      |   |