

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

January 2, 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 **November 13, 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

PC:jl



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 12/26/2013
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 C 11/13/2013
NAME OF PROVIDER OR SUPPLIER CENTERS FOR LIVING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 180 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 An unannounced on-site complaint investigation and investigation of facility self-reported incidents were conducted by the Division of Licensing and Protection on 11/12/13 and 11/13/13. There were regulatory deficiencies identified. The facility was found have Substandard Quality of Care related to the deficiencies found. The findings include;	F 000	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.		
F 224 SS=H	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to assure each resident is free from neglect and mistreatment, by failing to provide services necessary to avoid mental anguish for 1 of 4 residents (Resident #1) identified. The findings include; 1. Per review of the medical record of Resident #1, the record indicates that Resident #1 was admitted to the facility on 4/29/13 with diagnoses that include anxiety, depressive state and paranoid delusions. Per review of the facility internal investigation dated 11/8/13, on 11/6/13, Resident #1 purposefully ingested an unknown amount of Valium pills in an attempt to end his/her life. The investigation indicated that the	F 224	<u>F Tag 224</u> <u>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> Resident #1 was affected by the practice described in this Tag 224 with the potential to affect all residents. To address the immediate needs of Resident #1, LNA #1 was removed from Resident #1's care as room as the concerns were identified, which was on or about October 15, 2013. Resident #1 reported that he/she had ingested an unspecified amount of Valium pills. Resident #1 appeared to be at his/her normal baseline. He/she was transported to the local Emergency Room for evaluation. While at the ER the Resident remained at baseline. Medical testing showed no elevated levels of Valium in his/her system. Resident was returned to the facility. All residents with any with any documented medical history of anxiety or depression were evaluated for suicidal ideation and their care plans were reviewed to confirm appropriate interventions were in place. <u>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</u> 100% of interviewable residents were evaluated by Registered Nurses to confirm that all residents feel safe and to identify any residents who may have had any thoughts of suicidal ideation in the last 30 days. The following questions were used for discussion with all residents: Do you like your stay here? Are		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature] Administrator 01/02/2014

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.

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F 224	<p>Continued From page 1</p> <p>Resident #1 indicated that he/she wanted to kill themselves because of feelings he/she had that a facility staff member (LNA #1) was isolating Resident #1, stealing his/her things and trying to get the physician and other staff to drive Resident #1 crazy.</p> <p>The facility was aware that the Resident made frequent allegations/accusations about LNA #1, but did not take steps to avoid mental anguish for the resident. The direct care staff on the unit had to step in to make the decision that the LNA should not care for Resident #1 anymore; facility administration/leadership had not instituted that measure despite ongoing concerns/allegations. The resident indicated to staff at the Nursing home and at the hospital that the suicide attempt was related to LNA #1.</p> <p>Per interview with LNA #1, he/she confirmed that Resident #1 made numerous accusations regarding the LNA from 9/2013 to 11/8/13 and that the LNA reported these via email to the IDNS (Interim Director of Nursing). The LNA confirmed that he/she did not do direct care on Resident #1 after 10/15/13 but was still on the same unit as the resident and would see resident in hallway and in his/her room when the LNA walked by.</p> <p>Per review of the facility staffing sheets the LNA from 10/15/13 to 11/13/13 was not providing direct hands on care to Resident #1. Review of the staffing sheets indicated that the LNA was still working on the same unit (Moses) that the resident's room was on.</p> <p>Per interview with Resident #1 on 11/13/12, he/she confirmed that he/she was in need of help and that he/she did not want to be around LNA</p>	F 224	<p>you comfortable here? Has the staff treated you well? Have you had any suicidal thoughts in the last 30 days? No other residents were noted to be affected.</p> <p><u>3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur:</u></p> <p>The following facility policies were created and/or revised: Suicidal Ideation, Biopsychosocial Assessment and Reassessment, Referral for Social Services, Safety Checks, Resident's Own Medication Use of—CLR, and Plan of Care. An Interdisciplinary Care Team (IDT) was created. This team meets weekly with the purpose of reviewing all changes and concerns in resident condition and to confirm that all needed interventions are in place and are effective. The DNS and/or designee is the leader of this team.</p> <p>100% of all staff were educated on the following policies: Suicidal Ideation, Safety Checks, Resident's Own Medication Use of—CLR, and the Plan of Care.</p> <p>100% of all Nurses were educated on the following policies: Suicidal Ideation, Biopsychosocial Assessment and Reassessment, Referral for Social Services, Safety Checks, Resident's Own Medication Use of—CLR, and Plan of Care.</p> <p><u>4. How the corrective action will be monitored to ensure the deficient practice does not reoccur, i.e., what quality assurance program will be put into place:</u></p> <p>For the next four weeks, the DNS and/or designee will conduct a weekly random chart audit and resident interviews will be conducted to confirm that all residents' care plans are updated to incorporate the items identified in the IDT meeting and for compliance with the Suicidal Ideation and Safety</p>		

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F 224	Continued From page 2 #1. Resident #1 during the interview was observed to be weepy, shaking and broke into tears when speaking regarding the situation with the staff member. The Short Term Rehab Social Worker confirmed that Resident #1 had a long history of increasing behaviors and accusations towards LNA #1 and accusations of poor care and improper treatment. Per interview the IDNS confirmed that Resident #1 had made accusations for months regarding issues surrounding LNA #1. The IDNS confirmed that since admission Resident #1's behaviors and accusations would increase when in the presence of the LNA. Per review of the physician's assessment made on 11/6/2013, the physician indicates that Resident #1 is increasingly paranoid that one of the LNA's in the facility is conspiring to make his/her life miserable and today stated Resident #1 took a handful of Valium. The physician also indicates that Resident #1's perception of the LNA over powers any medical condition that the resident may be experiencing.	F 224	Checks policies, with random monthly chart audit thereafter for three months. The results of this audit will be reviewed by the Facility Safety-Quality Committee. The Social Services Coordinator will conduct a random monthly audit to review the biopsychosocial assessments for content and completion for the next 180 days, the results of which will be reviewed by the Facility Safety-Quality Committee. The Social Services Coordinator will conduct a random monthly audit to review conduct a random monthly audit to review compliance with the Social Services Referral policy and process completion for the next 90 days, the results of which will be assessed by the Facility Safety-Quality Committee. <u>5. Date of corrective action will be complete:</u> December 2, 2013 F224 POC accepted 11/21/14 PRACTICERW	
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	F 225	<u>F Tag 225</u> <u>1. What Corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> One resident (Resident #1) was affected by the practice described in Tag F225. To address the immediate needs of the resident, an investigation and report of the allegation of mistreatment, neglect or abuse was conducted by the Interim Director of Nursing Service (IDNS) and was reported to the state agency in the required timeframe. Resident #1 was affected by the practice described in this Tag 225 with the potential to affect all residents. To address the immediate needs of Resident #1, LNA #1 was removed from Resident #1's care as soon as the concerns were identified, which was on or about	

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F 225	<p>Continued From page 3 or licensing authorities.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to investigate allegations of mistreatment, neglect or abuse for 1 of 4 residents (Resident #1). The findings include; 1. Per review of the medical record of Resident #1, the record indicates that Resident #1 was admitted to the facility on 4/29/13 with diagnoses that include anxiety, depressive state and paranoid delusions. Per review of the facility internal investigation dated 11/8/13, on 11/6/13, Resident #1</p>	F 225	<p>October 15, 2013. Resident #1 reported that he/she had ingested an unspecified amount of Valium pills. Resident #1 appeared to be at his/her normal baseline. He/she was transported to the local Emergency Room for evaluation. While at the ER the Resident remained at baseline. Medical testing showed no elevated levels of Valium in his/her system. Resident was returned to the facility.</p> <p><u>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</u></p> <p>100% of interviewable residents were evaluated by Registered Nurses to confirm that all residents feel safe and to identify any residents who may have had any thoughts of suicidal ideation in the last 30 days. The following questions were used for discussion with all residents: Do you like your stay here? Are you comfortable here? Has the staff treated you well? Have you had any suicidal thoughts in the last 30 days? No other residents were noted to be affected.</p> <p><u>3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur:</u></p> <p>The facility's policy on Abuse, Neglect and Exploitation was revised. In addition, abuse reporting folders have been created and placed on each unit. The facility has educated 100% of all staff on abuse, neglect and exploitation. All new staff will complete this course as part of their orientation.</p> <p><u>4. How the corrective action will be monitored to ensure the deficient practice does not reoccur, i.e., what quality assurance program will be put into place:</u></p> <p>For the next four weeks, the DNS and/or designee will conduct a weekly random chart audit and</p>	

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F 225	Continued From page 4 purposefully ingested an unknown amount of Valium pills in an attempt to end his/her life. The investigation indicated that Resident #1 indicated that he/she wanted to kill themselves because of feelings he/she had that a facility staff member was isolating Resident #1, stealing his/her things and trying to get the physician and other staff to drive Resident #1 crazy. Resident #1, per the internal investigation was transferred to an acute care facility. Per review of an email from a patient advocate at the acute care facility dated 11/6/13 at 6:23 PM, the email was sent to Centers for Living Administrator, Interim Director of Nursing, Unit Manager and Social Worker. The email indicated that Resident #1 voiced to the patient advocate at the emergency room that Resident #1 was "dropped out of a lift," that Resident #1 had been "secluded" and is "not allowed visits with others", a facility staff member takes the resident's things and that a nurse is putting something in his/her tea causing him/her to have diarrhea. Per interview on 11/12/13 with the facility Administrator, he/she confirmed that he/she was aware of the accusations made by Resident #1 at the emergency room. The Administrator indicated that he/she was unaware if there were investigations for these accusations and also indicated that he/she was not aware if these incidences had been reported to the appropriate state agency because he/she didn't know if the paperwork existed. The Administrator indicated that the Interim Director of Nursing may know. Per interview with the Interim Director of Nursing (IDNS), he/she confirmed that he/she was aware of the accusations made by Resident #1 when at the emergency room on 11/6/13. The IDNS confirmed that he/she had not conducted any investigations regarding these accusations.	F 225	resident interviews will be conducted to confirm that all residents' care plans are updated to incorporate the items identified in the IDT meeting and for compliance with the Suicidal Ideation and Safety Checks policies, with random monthly chart audit thereafter for three months. The results of this audit will be reviewed by the Facility Safety-Quality Committee. 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 to ensure compliance and will provide correction and additional education as deviations are identified for the next 90 days. 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. <u>5. Date of corrective action will be complete:</u> December 2, 2013 Fdas POC accepted 11/14/13 [signature]		

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F 226 SS=D	<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 develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of 2 of 4 residents (Resident #1, #2) The findings include: 1. Per review of the facility internal investigation dated 11/8/13, on 11/6/13, Resident #1 purposefully ingested an unknown amount of Valium pills in an attempt to end his/her life. Resident #1, per the internal investigation was transferred to an acute care facility. Per review of an email from a patient advocate at the acute care facility dated 11/8/13 at 6:23 PM, the email was sent to Centers for Living Administrator, Interim Director of Nursing, Unit Manager and Social Worker. The email indicated that Resident #1 voiced to the patient advocate at the emergency room that Resident #1 was "dropped out of a lift," that Resident #1 had been "secluded" and is "not allowed visits with others", facility staff member takes the resident's things, and that a nurse is putting something in his/her tea causing him/her to have diarrhea. Per review of the facility internal investigations there were no investigations regarding any of the concerns communicated to the facility Administration on 11/6/13 by the patient advocate concerning allegations of potential abuse and</p>	F 226	<p><u>F Tag 226</u> <u>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>Two residents (Resident #1 and #2) were affected by the practice described in this Tag 226 with the potential to affect all residents. To address the immediate needs of Resident #1, LNA #1 was removed from Resident #1's care as soon as the concerns were identified, which was on or about October 15, 2013. Resident #1 reported that he/she had ingested an unspecified amount of Valium pills. Resident #1 appeared to be at his/her normal baseline. He/she was transported to the local Emergency Room for evaluation. While at the ER the Resident remained at baseline. Medical testing showed no elevated levels of Valium in his/her system. Resident was returned to the facility. The Emergency Room report revealed no signs of bruising or abrasions noted. Upon investigation of Resident #2's allegation it was found that she was experiencing some mental status changes related to urinary tract infection (UTI). Urine was obtained, and culture was found to be positive. She was noted to have had female caregivers. Family member reported hallucinations as a symptom of UTI in this resident. There were no physical findings or complaints of abuse once treatment of her UTI was initiated.</p> <p><u>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</u></p> <p>100% of interviewable residents were evaluated by Registered Nurses to confirm that all residents feel safe and to identify any residents who may have had any thoughts of suicidal ideation in the last 30 days. The following questions were used for discussion with all residents: Do you like your stay here? Are</p>		

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F 226	Continued From page 6 mistreatment. Per review of the facility policy and procedure titled "Abuse Neglect and Exploitation" last revised on 9/17/13, indicates that upon receiving information regarding potential suspected abuse to a resident, an internal investigation is to be conducted. Per interview on 11/12/13 with the facility Administrator, he/she confirmed that he/she was aware of the accusations made by Resident #1 at the emergency room. The Administrator indicated that he/she was unaware if there were investigations for these accusations and also indicated that he/she was not aware if these allegations had been reported to the appropriate state agency because he/she didn't know if the paperwork existed. The Administrator indicated that the Interim Director of Nursing may know. Per interview with the Interim Director of Nursing (IDNS), he/she confirmed that he/she was aware of the accusations made by Resident #1 when at the emergency room on 11/6/13. The IDNS confirmed that he/she had not conducted any investigations regarding these accusations. 2. Per review of the facility internal investigations, on 11/6/13, Resident #2 reported to the Licensed Nursing Assistant that he/she "felt like [he/she] had been raped." The investigation indicated that the Interim Director of Nursing was made aware upon arrival to the facility on 11/6/13. Per review of the investigation there was no evidence that the incident was reported to the appropriate state agency. Per interview with the Interim Director of Nursing on 11/13/13, he/she confirmed that this incident on 11/6/13 was not reported to the appropriate state agency per regulatory requirements. 3. Per review of the facility's policy and procedure titled Abuse Neglect and Exploitation Prohibition,	F 226	you comfortable here? Has the staff treated you well? Have you had any suicidal thoughts in the last 30 days? No other residents were noted to be affected. <u>3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur:</u> The facility's policy on Abuse, Neglect and Exploitation was revised. In addition, abuse reporting folders have been created and placed on each unit. The facility has educated 100% of all staff on abuse, neglect and exploitation. All new staff will complete this course as part of their orientation. The facility's policy on the use of lifts (Lifting, Manual) was revised. 100% of the nursing staff were educated on the use of mechanical lifts. All new staff will complete this course as part of their orientation. <u>4. How the corrective action will be monitored to ensure the deficient practice does not reoccur, i.e. what quality assurance program will be put into place:</u> For the next four weeks, the DNS and/or designee will conduct a weekly random chart audit to confirm that all notations of any alleged abuse, neglect, exploitation, criminal act or other indication of mental anguish on the part of any resident is fully documented, that appropriate clinical interventions are occurring, and that state reporting has occurred within the correct timeframe as required, the monthly audit thereafter for three months. The results of this audit will be reviewed by the Facility Safety-Quality Committee. The Corporate Compliance Officer will provide monitoring of 100% of state reported events for compliance with the state law requirements in the	

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F 250	Continued From page 9 feels neglected. On 11/12/13, Resident #1 verbalized that he/she was "going to go postal with a gun", and "If I really wanted to kill myself then I would wait until night because the night shift takes naps." Per review of the Social Service notes there was no evidence that Social Services addressed any of the documented concerns regarding Resident #1 on 6/23, 9/2, 9/8, 9/29, 9/30, 10/5, 11/10, 11/11 and 11/12/13. Per interview with the Short Term Rehab Social Worker, on 11/12/13, he/she indicated that he/she went to see Resident #1 on the morning of 11/6/13 to discuss the resident's interest to transfer to another facility. The Social Worker indicated that he/she saw the fax to the physician on 11/6/13 that indicated that the resident had expressed thoughts of suicide, that Resident #1 indicated he/she had to "get out of here", that "the nurse was out to get [him/her]", and "the doctor wanted [him/her] dead." The Social Worker indicated that Resident was "weepy" at the time also. The Social Worker indicated that he/she was made aware later in the day that Resident #1 had attempted suicide by swallowing undetermined amount of Valium. The Short Term Rehab Social Worker confirmed that Resident #1 had a long history of Increasing behaviors and accusations, especially accusations voiced by Resident #1 regarding a specific staff member, and Resident #1's accusations of poor care. Per interview on 11/13/13, the Long Term Care Social Worker reviewed the behavior documentation (noted above from 6/23/13 to 11/12/13) and he/she confirmed that there was no evidence that the Social Worker addressed any of these areas of concerns. The Long Term Care Social Worker confirmed that he/she was aware that Resident #1 had attempted to commit suicide	F 250	form of a review of 100% of event reports filed in the category of "State Report Filed". This monitoring will occur weekly to ensure compliance and will provide correction and additional education as deviations are identified for the next 90 days. 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. <u>5. Date of corrective action will be complete:</u> December 2, 2013. Full POC accepted 11/14/2013 <u>F Tag 250</u> <u>1. What Corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> One resident (Resident #1) was affected by the practice described in Tag F250 with the potential to affect all residents. To address the immediate needs of the resident, an investigation and report of the allegation of mistreatment, neglect or abuse was conducted by the Interim Director of Nursing Service (IDNS) and in this case it was reported to the state agency in the required timeframe. To address the immediate needs of Resident #1, LNA #1 was removed from Resident #1's care as soon as the concerns were identified, which was on or about October 15, 2013. Resident #1 reported that he/she had ingested an unspecified amount of Valium pills. Resident #1 appeared to be at his/her normal baseline. He/she was transported to the local Emergency Room for evaluation. Social Services, psychiatry, and united counseling services were part of the treatment for this resident. While at the ER the Resident remained at baseline. Medical testing showed no elevated levels of Valium in his/her system. Resident was returned to the facility	

2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

100% of interviewable residents were evaluated by Registered Nurses to confirm that all residents feel safe and to identify any residents who may have had any thoughts of suicidal ideation in the last 30 days. The following questions were used for discussion with all residents: Do you like your stay here? Are you comfortable here? Has the staff treated you well? Have you had any suicidal thoughts in the last 30 days? No other residents were noted to be affected.

3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?

The facility's policy on Abuse, Neglect and Exploitation was revised. In addition, abuse reporting folders have been created and placed on each unit. The facility has educated 100% of all staff on abuse, neglect and exploitation. All new staff will complete this course as part of their orientation.

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

Monitoring: For the next four weeks, the DNS and/or designee will conduct a weekly random chart audit and resident interviews will be conducted to confirm that all residents' care plans are updated to incorporate the items identified in the IDT meeting and for compliance with the Suicidal Ideation and Safety Checks policies, with random monthly chart audit thereafter for three months. The results of this audit will be reviewed by the Facility Safety-Quality Committee.

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F 250	Continued From page 10	F 250	The Social Services Coordinator will conduct a random monthly audit to review the biopsychosocial assessments for the content and completion for the next 180 days. The results will be assessed by the facility Safety - Quality Committee	
F 280 SS=D	on 11/6/13, and confirmed that Resident #1 had a long history of increasing behaviors and accusations especially accusations voiced by Resident #1 regarding a specific staff member and Resident #1's accusations of poor care. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to revise the comprehensive care plan for 1 of 4 residents identified (Resident #1) to reflect current resident status and goals and interventions to meet the specific needs of the resident. The findings include;	F 280	The Social Services Coordinator will conduct a random monthly audit to review compliance with the Social Services Referral Policy and process completion for the next 90 days, the results of which will be assessed by the facility Safety Quality Committee. 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 to ensure compliance and will provide correction and additional education as deviations are identified for the next 90 days. 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. <u>5. Dates corrective action will be completed:</u> December 2, 2013 F250 POC accepted 12/14 Pincote RW <u>F Tag 280</u> <u>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> The facility notes that the survey findings state that 2 residents were affected by the practice described in Tag 280 (Resident #1 and #3) with the potential to affect all residents. To protect the immediate safety of Resident #1, Resident #1's care plan was reviewed and fully updated. Resident #1's care plan was discussed at the Interdisciplinary Care Team (IDT) meeting. Social Services met with Resident	

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F 280	Continued From page 11 1. Per review of the medical record of Resident #1, the record indicates that Resident #1 was admitted to the facility on 4/29/13 with diagnoses that include anxiety, depressive state and paranoid delusions. Per review of the behavior documentation: On 9/2/03 Resident #1 is "easily agitated, threatening to throw self from bed" and that resident's behaviors are increasing. On 9/8/13, Resident #1 expresses depressed or hopeless "Would rather be dead". On 9/29/13, Resident #1 is withdrawn and negative. On 9/30/13, Resident #1 expressed that "I am nothing", "I am no use to anyone", "nothing matters", "would rather be dead", "what's the use", "why can't I die." On 10/5/13 Resident #1 verbalizes that "I am of no use to anyone", "Nothing matters", what's the use" and is easily annoyed. On 11/6/13, Resident #1 threatens to commit suicide in the morning and then when left alone for a minute by staff on 11/6/13, he/she swallows an undetermined amount of Valium that he/she had, and the resident is transferred to the emergency room. On 11/10/13, Resident #1 verbalized that he/she said "I wish I had a gun so I could clean house around here." On 11/11/13, Resident #1 verbalizes that "the resident across the hall should be shot." Resident #1 also verbalizes that he/she knows she is in crisis and that he/she needs help and feels neglected. On 11/12/13, Resident #1 verbalized that he/she was "going to go postal with a gun", and "If I really wanted to kill myself then I would wait until night because the night shift takes naps." Per review of the Comprehensive Assessment	F 280	#1 multiple times to discuss her social service needs. An advocate has been established for this resident. The resident is participating in bi-weekly therapy sessions. Resident #3's safety status was re-evaluated and changes were made accordingly and updated in the care plan. <u>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</u> The care plans for all residents were reviewed. <u>3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur:</u> The facility policy "Plan of Care" was revised. Education for all nurses was completed about this policy change to include when and how to update the care plan. <u>4. How the corrective action will be monitored to ensure the deficient practice does not reoccur, i.e., what quality assurance program will be put into place:</u> The DNS and/or designee and the facility medical director will have a standing weekly meeting to discuss any issues or concerns about the residents. 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 incorporate the items identified in the IDT meeting, with monthly random chart audit for three months. The results will be reviewed by the facility Safety-Quality Committee. <u>5. Date of corrective action will be complete:</u> December 2, 2013 F280 POC accepted 11/21/14 P.M.C.L.A.P.N	

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F 280	Continued From page 12 (MDS) dated 10/2/2013; Resident #1 has diagnoses of paranoid delusions, anxiety and depression. During 2-6 days in assessment period Resident #1 had little interest or pleasure doing things, and he/she had trouble falling asleep 12-14 days during the assessment period. Resident #1 was feeling tired and had little energy on 12-14 days during the assessment period and was delusional and displaying behaviors. Per review of the Comprehensive Care Plans provided by the facility, there was no evidence on the care plan dated 11/8/13, that the specific issues noted in the medical record and behavior records on 9/2, 9/8, 9/29, 9/30, 10/5, 11/6, 11/10, 11/11, and 11/12 were addressed on the resident's care plan to reflect the resident's specific needs and interventions and goals placed to prevent situations from reoccurring. Per interview with the Interim Director of Nursing on 11/13/13, he/she reviewed the comprehensive care plan dated 10/2/13 and confirmed that the care plan did not reflect the specific needs of Resident #1 and interventions and goals established to help Resident #1 manage and prevent behavior issues and concerns.	F 280	<u>F282</u> <u>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> Two residents (Resident #1 and Resident #3) were affected by the practice described in Tag 282 with the potential to affect all residents. To protect the immediate safety of Resident #1, Resident #1's care plan was reviewed and fully updated. Resident #1's care plan was discussed at the Interdisciplinary Care Team (IDT) meeting. Social Services met with Resident #1 multiple times to discuss her social service needs. An advocate has been established for this resident. The resident is participating in bi-weekly therapy sessions. Resident #3's safety status was re-evaluated and changes were made accordingly and updated in the care plan.	
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide or arrange services by	F 282	<u>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</u> 100% of interviewable residents were evaluated by Registered Nurses to confirm that all residents feel safe and to identify any residents who may have had any thoughts of suicidal ideation in the last 30 days. The following questions were used for discussion with all residents: Do you like your stay here? Are you comfortable here? Has the staff treated you well? Have you had any suicidal thoughts in the last 30 days? No other residents were noted to be affected. <u>3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur;</u> The following facility policies were created and/or revised: Suicidal Ideation, Biopsychosocial Assessment and Reassessment, Referral for Social Services, and Safety Checks, and Plan of Care. An	

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F 282	Continued From page 13 qualified persons in accordance with the written care plans for 2 of 4 residents identified (Resident #1 and #3). The findings include: 1. Per review of the medical record of Resident #1, the record indicates that Resident #1 was admitted to the facility on 4/29/13 with diagnoses that include anxiety, depressive state and paranoid delusions. Per review of the behavior documentation: On 6/23/13 Resident #1 exhibits behavior to intentionally cause harm when lifting in wheelchair tries to fall forward, holds pills in throat and tries to choke, displays extreme anger. On 9/2/03 Resident #1 is "easily agitated, threatening to throw self from bed" and that resident's behaviors are increasing. On 9/8/13, Resident #1 expresses depressed or hopeless thoughts "Would rather be dead". On 9/29/13, Resident #1 is withdrawn and negative. On 9/30/13, Resident #1 expressed that "I am nothing", "I am no use to anyone", "nothing matters", "would rather be dead", "what's the use", "why can't I die." On 10/5/13 Resident #1 verbalizes that "I am of no use to anyone", "Nothing matters", "what's the use" and is easily annoyed. On 11/6/13, Resident #1 threatens to commit suicide in the morning and then when left alone for a minute by staff on 11/6/13, he/she swallows an undetermined amount of Valium that he/she had, and the resident is transferred to the emergency room. On 11/10/13, Resident #1 verbalized that he/she said "I wish I had a gun so I could clean house around here." On 11/11/13, Resident #1 verbalizes that "the resident across the hall should be shot." Resident #1 also verbalizes that he/she knows	F 282	Interdisciplinary Care Team (IDT) was created. This team meets weekly with the purpose of reviewing all changes and concerns in resident condition and to confirm that all needed interventions are in place and are effective. The DNS and/or designee is the leader of this team. The care plans for all residents were reviewed. Education was provided to all Social Workers on the following policies: Suicidal Ideation, Safety Checks, Biopsychosocial Assessment and Reassessment, and the Plan of Care. 100% of all Nurses were educated on the following policies: Suicidal Ideation, Biopsychosocial Assessment and Reassessment, Referral for Social Services, Safety Checks, and Plan of Care. <u>4. How the corrective action will be monitored to ensure the deficient practice does not reoccur, i.e., what quality assurance program will be put into place:</u> 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 incorporate the items identified in the IDT meeting, with monthly random chart audit for three months. The results will be reviewed by the facility Safety-Quality Committee. For the next 30 days, the Unit Managers or designees will identify all residents on safety checks and conduct a daily review of the documentation of the safety checks to confirm that they are being conducted and correctly documented, with weekend reviews occurring on Mondays, and a random sample of records reviewed for three months thereafter. The Social Services Coordinator will conduct a random monthly audit to review the biopsychosocial assessments for content and completion for the next		

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F 282	<p>Continued From page 14</p> <p>she is in crisis and that he/she needs help and feels neglected.</p> <p>On 11/12/13, Resident #1 verbalized that he/she was "going to go postal with a gun", and "If I really wanted to kill myself then I would wait until night, because the night shift takes naps."</p> <p>Per review of the Social Service notes there was no evidence that Social Services addressed any of the documented concerns regarding Resident #1 on 6/23, 9/2, 9/8, 9/29, 9/30, 10/5, 11/10, 11/11 and 11/12/13.</p> <p>Per review of the comprehensive care plan dated 7/9/13, the care plan indicates that Social Services is to make 1:1 visits as needed, allow resident to ventilate. Review of the care plan dated 11/8/13 the care plan indicates that nursing is to consult social services when behaviors escalate or mood deteriorates.</p> <p>Per interview on 11/13/13 with the Interim Director of Nursing, he/she reviewed the comprehensive care plan and confirmed that services were not provided by qualified persons in accordance with Resident #1's plan of care. Per interview with the Long Term Social Worker on 11/13/13, he/she indicated that Nursing staff had not notified him/her of Resident #1's behaviors as they increased or deterioration of Resident #1's mood state as per the care plan.</p> <p>2. The facility failed to show evidence the care plan was implemented by failing to assure staff documentation of every 15 minute safety checks for Resident #3. Review of 15 minute safety checks show that they have not been completed consistently since August 13, 2013. 7 out of 7 days had incomplete data from 8/13-8/19. The dates of 8/22-8/28 were presented with 4 days of incomplete data. September data was complete</p>	F 282	<p>180 days, the results of which will be reviewed by the Facility Safety-Quality Committee.</p> <p>The Social Services Coordinator will conduct a random monthly audit to review conduct a random monthly audit to review compliance with the Social Services Referral policy and process completion for the next 90 days, the results of which will be assessed by the Facility Safety-Quality Committee.</p> <p><u>5. Date of corrective action will be complete:</u></p> <p>December 2, 2013</p> <p>F282 POC accepted 1/2/14 Pincot RN</p>		

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F 282	Continued From page 15 for all days except 9/22/13, which was the day Resident fell with injury resulting. There is no documentation for the dates of 10/7, 10/8, 10/13 or 10/14. There was sporadic data completion for the month of October and for 10/22-10/28 there were entire shifts without completion of information. Medical records personnel stated that there were no safety sheets for this resident in medical records, nor overflow. The facility was not able to produce the missing documentation. Per interview at 1:10 PM on 11/13/13, the nurse on unit stated that they could not verify that the checks have been completed the way they are suppose to be. Confirmed that the care plan reflects they are to be done every 15 minutes and documented. Per interview at 1:55 PM on 11/13/13, the Unit Manager confirmed that the documentation is to be done on the safety check documentation form every 15 minutes. The Unit Manager further confirmed that the care plan reflects that Resident #3 is to have documented 15 minute safety checks.	F 282	<u>F Tag 319</u> 1. <u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> One resident (Resident #1) was affected by the practice described in this Tag 319 with the potential to affect all residents. To address the immediate needs of Resident #1, consultations with Social Services, Resident #1's primary care physician, a psychiatrist, and United Counseling Services (the community mental health service) were all requested and occurred. To further provide for the immediate safety of Resident #1 and all residents, the residents with any with any documented medical history of anxiety or depression were evaluated for suicidal ideation and their care plans were reviewed to confirm appropriate interventions were in place.	
F 319 SS=M	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure that 1 of 4 residents (Resident #1) who displays mental or psychosocial adjustment difficulty receives	F 319	2. <u>How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken?</u> 100% of interviewable residents were evaluated by Registered Nurses to confirm that all residents feel safe and to identify any residents who may have had any thoughts of suicidal ideation in the last 30 days. The following questions were used for discussion with all residents: Do you like your stay here? Are you comfortable here? Has the staff treated you well? Have you had any suicidal thoughts in the last 30 days? No other residents were noted to be affected. 3. <u>What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?</u> The following facility policies were created and/or revised: Suicidal Ideation, Biopsychosocial Assessment and Reassessment, Referral for Social Services, Safety Checks, Resident's Own	

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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 319	Continued From page 16: appropriate treatment and services to correct the assessed problem. 1. Per review of the medical record of Resident #1, the record indicates that Resident #1 was admitted to the facility on 4/29/13 with diagnoses that include anxiety, depressive state and paranoid delusions. Per review of the facility internal investigation dated 11/8/13, on 11/6/13, Resident #1 purposefully ingested an unknown amount of Valium pills in an attempt to end his/her life. The investigation indicated that the Resident #1 indicated that he/she wanted to kill themselves because of feelings he/she had that a facility staff member (LNA #1) was isolating Resident #1, stealing his/her things and trying to get the physician and other staff to drive Resident #1 crazy. The facility failed to meet the psychosocial needs by failing to identify, recognize and provide services for signs of psychosocial difficulties prior to the suicide attempt, failing to protect the resident from mental anguish by allowing LNA #1 to continue to be around Resident #1 despite months of ongoing allegations against LNA #1, failing to implement their policy regarding a resident who makes suicidal statements, failing to revise and implement the resident's plan of care, failing to thoroughly investigate allegations and complaints made by the resident, and failing to provide services by qualified mental health professionals as indicated. Per interview with LNA #1, he/she confirmed that Resident #1 made numerous accusations regarding the LNA and that the LNA reported these via email to the IDNS. The LNA confirmed that he/she did not do direct care on Resident #1 since 10/15/13 but was still on the same unit as the resident and would see resident in hallway and in room when the LNA walked by.	F 319	Medication Use of CLR, and Plan of Care. An Interdisciplinary Care Team (IDT) was created. This team meets weekly with the purpose of reviewing all changes and concerns in resident condition and to confirm that all needed interventions are in place and are effective. The DNS and/or designee is the leader of this team. 100% of all staff were educated on the following policies: Suicidal Ideation, Safety Checks, and the Plan of Care. 100% of all Nurses were educated on the following policies: Suicidal Ideation, Biopsychosocial Assessment and Reassessment, Referral for Social Services, Safety Checks, and Plan of Care. 100% of Social Workers were educated on the following policies: Suicidal Ideation, Biopsychosocial Assessment and Reassessment, Referral for Social Services, Safety Checks, and Plan of Care. <u>4. How the corrective action will be monitored to ensure the deficient practice does not reoccur, i.e., what quality assurance program will be put into place:</u> For the next four weeks, the DNS and/or designee will conduct a weekly random chart audit and resident interviews will be conducted to confirm that all residents' care plans are updated to incorporate the items identified in the IDT meeting and for compliance with the Suicidal Ideation and Safety Checks policies, with random monthly chart audit thereafter for three months. The results of this audit will be reviewed by the Facility Safety-Quality Committee. The Social Services Coordinator will conduct a random monthly audit to review the biopsychosocial assessments for content and completion for the next		

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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 319	Continued From page 17 Per interview with the Interim Director of Nursing (IDNS), he/she confirmed that he/she was aware of the accusations made by Resident #1 when at the emergency room regarding LNA #1 on 11/6/13. Per interview the IDNS confirmed that Resident #1 had made accusations for months regarding issues surrounding a facility Licensed Nursing Assistant (LNA). The IDNS confirmed that since admission Resident #1's behaviors and accusations would increase when in the presence of the LNA and that the floor staff had decided on 10/15/13 to not have the LNA care for Resident #1 because of the increase in behaviors. Per interview with the IDNS on 11/12/13 he/she indicated that since Resident #1 returned to the facility on 11/6/13 psychiatric services were attempting to be obtained for Resident #1 but that United Counseling Services had indicated that they would not follow this resident because of who his/her doctor was. The IDNS was unable to explain the rationale for this decision but felt it maybe of a political nature.	F 319	180 days, the results of which will be reviewed by the Facility Safety-Quality Committee. The Social Services Coordinator will conduct a random monthly audit to review conduct a random monthly audit to review compliance with the Social Services Referral policy and process completion for the next 90 days, the results of which will be assessed by the Facility Safety-Quality Committee. <i>S. Date of corrective action will be complete:</i> December 2, 2013 F319 POC accepted 11/21/13 P. W. O. T. A. R. N.		
F 323 SS=H	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the	F 323	F Tag 323 1. What Corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 was affected by the practice described in this Tag 323 with the potential to affect all residents. To address the immediate needs of Resident #1, LNA #1 was removed from Resident #1's care as soon as the concerns were identified, which was on or about October 15, 2013. Resident #1 reported that he/she had ingested an unspecified amount of Valium pills. Resident #1 appeared to be at his/her normal baseline. He/she was transported to the local Emergency Room for evaluation. While at the ER the Resident remained at baseline. Medical testing showed no elevated levels of Valium in his/her system. Resident was returned to the facility. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? To address the immediate needs of Resident #1 and all other residents at risk of suicidal ideation, an immediate sweep was conducted of 100% of residents to review medication safety, inquire about		

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F 323	Continued From page 18 facility failed to ensure that 1 of 4 residents (Resident #1) receives adequate supervision and assistance devices to prevent accidents. The practice also has the potential to affect all other residents of the facility. The findings include; 1. Per review of the medical record of Resident #1, the record indicates that Resident #1 was admitted to the facility on 4/29/13 with diagnoses that include anxiety, depressive state and paranoid delusions. Per review of the facility internal investigation dated 11/8/13, on 11/6/13, Resident #1 purposefully ingested an unknown amount of Valium pills in an attempt to end his/her life. Per review of the facility internal investigation, Resident #1 indicated in interview that he/she had the Valium and other pills on admission to the facility. Per interview with Interim Director of Nursing Resident #1 also had Lexapro and an over the counter medication possibly Miralax in his/her possession on 11/6/13. Per interview with the IDNS on 11/13/13, he/she indicated that the facility does not ask upon admission if a new resident has any medications in their possession. The IDNS indicated that the facility does not have any system on admission that would ensure that medications prescribed to a resident prior to admission did not enter the facility without the staff's knowledge. 2. Per the facility internal investigation Resident #1 was placed on immediate supervision with facility staff after informing staff on the morning of 11/6/13 that Resident #1 wants to kill him/herself. Per the internal investigation, because Resident #1 had not made any other negative statements, per nursing judgment, the resident was placed on 15 minute checks. Per the investigation, the resident was left alone and when the nursing student left the room, the	F 323	any home medications that are held by the resident while in the facility, to educate residents and their family members about the importance of not taking home medications without the knowledge of care providers, and to obtain permission to check the belongings of residents to confirm that no undisclosed medications are in the possession of resident. 100% of interviewable residents were evaluated by Registered Nurses to confirm that all residents feel safe and to identify any residents who may have had any thoughts of suicidal ideation in the last 30 days. The following questions were used for discussion with all residents: Do you like your stay here? Are you comfortable here? Has the staff treated you well? Have you had any suicidal thoughts in the last 30 days? No other residents were noted to be affected. <u>3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?</u> The following facility policies were reviewed and/or revised: "Resident's Own Medication, Use of—, CLR" and "Admission of the Resident". 100% of nurses were educated on the policy changes including medication safety review with all residents and/or their POA's upon admission to the facility. The quarterly MDS review process will include a review of all medications used by the residents to confirm that all residents' records are fully accurate. This will be completed through a record review and via a face-to-face meeting with each resident. For the next four weeks, the DNS and/or designee will conduct a weekly random chart audit for compliance with the "Admission of the Resident", "Suicidal Ideation", and "Safety Checks" policies, with a random monthly audit for three months	

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F 323	Continued From page 19 resident purposefully ingested an unknown amount of Valium. Per the investigation, when the nurse reentered the room Resident #1 informed the nurse that he/she had just taken a handful of pills in attempt to take his/her own life. Per review of the facility policy and procedure titled Suicidal Ideation Prevention and/or Management of Harmful behaviors indicates that, "Any resident/patient verbalizing that he/she wishes to harm him/herself or demonstrating self-destructive behavior will be taken seriously, no matter how vague or seemly immaterial". The policy also indicates "A staff or family member will be immediately assigned to stay with a resident/patient until the resident/patient is appropriately evaluated or transferred."	F 323	thereafter. The results of this audit will be reviewed by the Facility Safety-Quality Committee. <u>5. Date of corrective action will be complete:</u> December 2, 2013 F323 POC accepted 11/14/13 ANCOBAN <u>F Tag 490</u> <u>1. What Corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u>		
F 490 SS=H	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on regulatory violations found at the actual harm level at F224, F250, F319 and F323, and violations regarding the same resident at F225, F226, F280 and F282 (Resident #1), the facility is not administered in a manner that enables it to use its resources effectively to attain the highest practicable mental and psychosocial well being for residents of the facility. 1. The facility failed to assure Resident #1 is free	F 490	1. The Facility failed to assure Resident #1 is free from neglect and mistreatment by staff. Refer to POC F224 2. The facility failed to assure allegations of abuse are thoroughly investigated and failed to implement abuse policies. Refer to POC F225 & F 226 3. The facility failed to provide adequate social services. Refer to POC F250 4. The facility failed to revise the care plan to reflect significant changes in psychosocial well being and failed to implement the existing plan of care as written. Refer to POC F280 & F282 5. The facility failed to provide adequate treatment for mental and psychosocial difficulties. Refer to POC F319 6. The facility failed to have any process to evaluate if residents bring prescription and/or over the counter medication from home that is accessible to them during their stay. Refer to POC F323 <u>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</u> 1. The Facility failed to assure Resident #1 is free from neglect and mistreatment by staff. Refer to POC F224		

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F 490	Continued From page 20 from neglect and mistreatment by staff (Refer to F224); 2. The facility failed to assure allegations of abuse are thoroughly investigated and failed to implement abuse policies (Refer to F225 & F226); 3. The facility failed to provide adequate social services (Refer to F250); 4. The facility failed to revise the care plan to reflect significant changes in psychosocial well-being and failed to implement the existing plan of care as written (Refer to F280 and F282); 5. The facility failed to provide adequate treatment for mental and psychosocial difficulties (Refer to F319); 6. The facility failed to have any process to evaluate if residents bring prescription and/or over the counter medication from home that is accessible to them during their stay (Refer to F323).	F 490	2. The facility failed to assure allegations of abuse are thoroughly investigated and failed to implement abuse policies. Refer to POC F225 & F 226 3. The facility failed to provide adequate social services. Refer to POC F250 4. The facility failed to revise the care plan to reflect significant changes in psychosocial well – being and failed to implement the existing plan of care as written. Refer to POC F280 & F282 5. The facility failed to provide adequate treatment for mental and psychosocial difficulties. Refer to POC F319 6. The facility failed to have any process to evaluate if residents bring prescription and/or over the counter medication from home that is accessible to them during their stay. Refer to POC F323 <u>3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur:</u> 1. The Facility failed to assure Resident #1 is free from neglect and mistreatment by staff. Refer to POC F224 2. The facility failed to assure allegations of abuse are thoroughly investigated and failed to implement abuse policies. Refer to POC F225 & F 226 3. The facility failed to provide adequate social services. Refer to POC F250 4. The facility failed to revise the care plan to reflect significant changes in psychosocial well – being and failed to implement the existing plan of care as written. Refer to POC F280 & F282 5. The facility failed to provide adequate treatment for mental and psychosocial difficulties. Refer to POC F319 6. The facility failed to have any process to evaluate if residents bring prescription		

and/or over the counter medication from home that is accessible to them during their stay. Refer to POC F323.

4. How the corrective action will be monitored to ensure the deficient practice does not reoccur, i.e. what quality assurance program will be put into place:

1. The Facility failed to assure Resident #1 is free from neglect and mistreatment by staff. Refer to POC F224
2. The facility failed to assure allegations of abuse are thoroughly investigated and failed to implement abuse policies. Refer to POC F225 & F 226
3. The facility failed to provide adequate social services. Refer to POC F250
4. The facility failed to revise the care plan to reflect significant changes in psychosocial well-being and failed to implement the existing plan of care as written. Refer to POC F280 & F282
5. The facility failed to provide adequate treatment for mental and psychosocial difficulties. Refer to POC F319
6. The facility failed to have any process to evaluate if residents bring prescription and/or over the counter medication from home that is accessible to them during their stay. Refer to POC F323

5. Date of corrective action will be complete:

December 2, 2013

F490 POC accepted 11/2/14 pvtalark