

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 18, 2012

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

Provider #: 475029

Dear Mr. Bodemer:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **December 8, 2011**. Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure



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

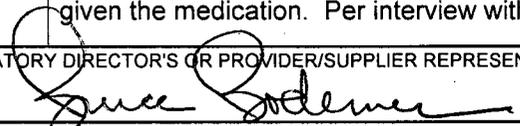
RECEIVED
Division of

PRINTED: 12/20/2011
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 _____ <p style="text-align: right;">JAN 03 12 Licensing and Protection</p>	(X3) DATE SURVEY COMPLETED C 12/08/2011
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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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(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	<p>INITIAL COMMENTS</p> <p>An unannounced on-site complaint investigation was conducted on 11/30/11 as a result of a self reported complaint filed by the facility with the Division of Licensing and Protection. The investigation was concluded on 12/8/11 after further offsite review. The following regulatory issues were identified:</p> <p>F 281 SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide services to 1 of 2 Residents reviewed in the sample (Resident #1) related to failure to follow physicians written orders in the administration of a medication to be given once daily. The findings include:</p> <p>Per review of the nursing notes, Resident #1 was admitted on 1/16/2008 with active diagnosis of- Hypertension (high blood pressure), Cerebral Vascular Disease and Cerebral Ischemia (stroke). Per physician order dated 1/16/2008 on admission, Resident #1 was to receive Plavix (medication used to prevent heart attack, stroke, or other vascular events) 75 mg PO (by mouth) each day. Per review of the facilities internal investigation conducted on November 15, 2011, the day-shift medication nurse was identified and admitted to signing that he/she administered Plavix daily to Resident #1 but had not actually given the medication. Per interview with the</p>	F 000	<p>F281 Resident #1 no longer resides in the facility.</p> <p>The SVMC pharmacy is in the process of attempting to generate a report dating back to 12/1/11 of any medications returned for credit from the facility. Once that report is received, an investigation will be conducted. Reasons for the medication being returned will be attempted to be found. Results of the initial investigation will be reported at the January Safety-Quality meeting.</p> <p>The nursing staff will be re-educated regarding the process and documentation of medication refusal and proper medication disposal.</p> <p>Beginning with the January 2, 2012 medication cart turn around, the pharmacy will send a report to the</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE **ADMINISTRATOR** (X6) DATE **12/29/11**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

pmc

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F 281	Continued From page 1 evening medication nurse and evening house supervisor on 11/30/2011 at 3:19 PM, it was identified that prior to November 2, 2011 the nurses on evenings had identified that Resident #1's daily dose of Plavix was returned to the pharmacy every week (5 doses) each week for three weeks and that the day nurse had signed on each day that he/she worked that the dose was given. Per review of the pharmacy medication return requisition for Resident #1's Plavix, from October 1, 2011 to November 14, 2011, 19 doses had been returned to the pharmacy that should have been administered to the patient. Per interview with the DNS on 11/30/11 at 2:34 , he/she confirmed that 19 doses had been returned to the pharmacy between 10/1/11 through November 14, 2011 and not administered to Resident #1, per physician order.	F 281	DNS. Any medications returned for credit will be reported. A report will be generated each time a medication care (a total of seven in the building) is "turned around." Full review of said report will be completed by DNS/nurse manager/designee. DNS/designee will keep a log of medications returned to the pharmacy for credit and the reason why. Results will be reported to CLR Safety-Quality for a total of 3 months. <i>F281 POC accepted 1/2/12 McLuharen, Director</i>	1/13/12
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 of 2 Residents (Resident #1) regarding the failure to administer medications and failure to	F 309	<u>F309</u> - Resident #1 no longer resides in the facility. The SVMC pharmacy is in the process of attempting to generate a report dating back to 12/1/11 of any medications returned for credit from the facility. Once that report is received, an investigation will be conducted. Reasons for the medication being returned will be attempted to be found. Results of the initial investigation will be reported at the	

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F 309	Continued From page 2 communicate and investigate the failure to administer medications as ordered. The findings include: 1. Per review of the nursing notes, Resident #1 was admitted on 1/16/2008 with active diagnosis of- Hypertension (high blood pressure), Cerebral Vascular Disease and Cerebral Ischemia (stoke). Per physician order dated 1/16/2008 on admission, Resident #1 was to receive Plavix (used to prevent heart attack, stroke, or other vascular events) 75 mg PO (by mouth) each day. Per review of the facility's internal investigation conducted on November 15, 2011, the day-shift medication nurse admitted to signing that he/she administered Plavix daily to Resident #1 but had not actually given the medication. Per interview with the evening medication nurse and evening house supervisor on 11/30/2011 at 3:19 PM, it was identified that prior to November 2, 2011 the nurses on evenings had identified that Resident #1's daily dose of Plavix was returned to the pharmacy every week (5 doses) each week for three weeks and that the day nurse had signed on each day that he/she worked the dose was given. Per review of the pharmacy medication return requisition form for Resident #1, from October 1, 2011 to November 14, 2011, 19 doses had been returned to the pharmacy that should have been administered to the patient. Per interview with the DNS on 11/30/11 at 2:34 , he/she confirmed that 19 doses had been returned to the pharmacy between 10/1/11 through November 14, 2011 and not administered to Resident #1 per physician order. 2. Per interview on 11/30/11, the evening nurse indicated that at the beginning of October during	F 309	January Safety-Quality meeting. After speaking with the unit manager and supervisors of the facility it was determined that no nursing staff have reported any medication being left in the drawer that should have been administered. The nursing staff will be re-educated regarding the process and documentation of medication refusal and proper medication disposal. The nursing supervisor staff will be re-educated about what constitutes a report to the DNS. They will also be re-educated regarding event reports and what constitutes an event of not. Beginning with the January 2, 2012 medication cart turn around, the pharmacy will send a report to the DNS. Any medications returned for credit will be reported. A report will be generated each time a medication care (a total of seven in the building) is "turned around." Full review of said report will be completed by DNS/nurse		

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F 309	<p>Continued From page 3</p> <p>the weekly medication change over (return of discontinued and refused medications with the pharmacy) it was identified that Resident #1 had 5 pills of Plavix being returned to the pharmacy out of a 7 day supply. He/she indicated that the medication administration record had been signed by the day nurse that all doses had been given. The evening nurse indicated that the facility only receives 7 days worth of Plavix at a time and that unless the resident had refused to take the medication it should not be in the drawer to go back to the pharmacy. The evening nurse indicated he/she had reported this to the evening supervisor. The evening nurse also indicated that the same thing occurred the following week, 10/8/11 to 10/13/11, and 5 doses of Plavix were returned to the pharmacy but the medication record indicated they were administered to Resident #1 and again during the week of 10/14/11 to 10/10/11 and each time this was reported to the evening supervisor.</p> <p>Per interview with the Evening Supervisor on 11/30/11 at 3:19 PM, he/she indicated that he/she was notified by the evening nurse each week that Resident #1's Plavix was being returned to the pharmacy at change over, even though it was signed in the MAR as given by the day nurse. The evening supervisor indicated he/she reported this to the night supervisor during the week of 10/13. He/she indicated that when it was reported to him/her the week of 10/20/11 that again 5 doses of Plavix for Resident #1 were returned to the pharmacy, he/she then reported it to the Unit Manager.</p> <p>Per interview with the Unit Manager (UM) and the Director of Nursing Services (DNS) on 11/30/11</p>	F 309	<p>manager/designee. All monitors and logs will be reported to CLR Safety-Quality for 3 months.</p> <p><i>F309 POC accepted 1/2/12 M. Culhan RN / Amcota RN</i></p>	1/13/12

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F 309	Continued From page 4 at 3:19 PM, the DNS and UM confirmed that it was communicated to them on 11/2/11 by the evening nurse of the 15 Plavix pills being returned to the pharmacy and that the day nurse was signing the MAR that the pills were administered to the resident. The DNS confirmed that a written counseling statement was given to the day nurse regarding the return of the Plavix to the pharmacy and the signing of the medication record that the Plavix was signed as administered. Review of the medication record shows from 10/1 to 11/2, Resident #1's Plavix was signed that 15 doses were administered to the resident. Review of the pharmacy medication reconciliation form for Resident #1 from 10/1 to 11/17, 19 doses were returned to the pharmacy. Review of the facility event reporting policy for medication related events, "when an event is discovered the employee must complete a event reporting report and this report will be forwarded to the responsible supervisor or manager for their review and investigation". The policy also indicates that the "physician should be notified of the event". Per review of the nurses notes the physician was not notified until 11/15/11. The DNS confirmed that no investigation was done prior to 11/15/11 and the DNS was unable to provide any medication error reports for the failure to administer medication to a resident per physician orders prior to 11/15/11.	F 309			

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12/29/11