



AGENCY OF HUMAN SERVICES  
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING  
Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 241-2345  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 241-2358

August 18, 2010

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

Dear Mr. Bodemer:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on July 19, 2010. 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,

A handwritten signature in cursive script that reads "Pamela M. Cota".

Pamela M. Cota, RN  
Licensing Chief



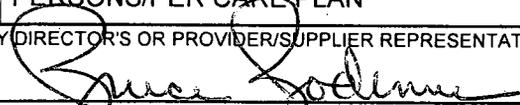
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475029</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/19/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CENTERS FOR LIVING AND REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 HOSPITAL DRIVE BENNINGTON, VT 05201</b>
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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	INITIAL COMMENTS	F 000	We carefully reviewed all residents for whom alarms had been ordered.	6/2/10
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide services in accordance with professional standards of practice for one resident. ( Resident #1) Findings include:  1. Per record review and confirmed by staff interview, the facility failed to ensure all safety related alarms were in place after a transfer within the facility. Resident #1 was transferred from the Rockwell subacute care unit to the Frost long term care unit on 4/15/10, without one of the three alarm devices the resident had been care planned for and was using prior to the transfer. Interview with the Director of Nursing Service (DNS) on 7/19/10 at 2:30 PM confirmed that the staff involved with the transfer of this resident failed to adhere to professional practice standards and the facility procedure regarding complete transfer and admission reporting and assessment.  Reference: ANA Scope and Standards of Gerontological Nursing Practice , 2nd Edition, 2001.	F 281	We updated facility policy regarding in-house transfers.  By 8/6/10 our staff educator will have completed training on the policy revision with all staff.  We have implemented a checklist that will be part of the unit transfer process that carefully addresses safety alarms.  The receiving unit manager is responsible to verify completion of unit transfer with the completion of the transfer.  The unit manager will report to the DNS weekly, summarizing documentation around the transfer. The DNS will present a summary of the audit results monthly at the Quality / Safety Committee meeting. Since the next Quality / Safety meeting is not scheduled until 8/26/10, the August report will be reported 8/13/10 at the Administrator Stand-Up meeting to enable compliance with the 8/19/ 10 provided to us by your agency. See Exhibit "A"	7/22/10 8/6/10 8/6/10 8/6/10 8/13/10
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	F281 POC Accepted 8/17/10 [Signature]	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>ADMINISTRATOR</b>	(X6) DATE <b>7/30/10</b>
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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.

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

RECEIVED  
Division of  
AUG 13

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NAME OF PROVIDER OR SUPPLIER  <b>CENTERS FOR LIVING AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 HOSPITAL DRIVE BENNINGTON, VT 05201</b>		
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F 282	Continued From page 1  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 staff interview and record review, the facility failed to provide care and services in accordance with the resident's written plan of care. (Resident #1) Findings include:  1. Per record review on 7/19/10, nursing staff failed to provide a rise alarm (alarm that alerts staff when a Resident is attempting to rise independently) for Resident #1 in accordance with the resident's written plan of care (POC). The Resident sustained a fall on 5/28/10, at which time it was discovered that the rise alarm was not in use. During an interview with the Director of Nursing Service (DNS) on 7/19/10 at 2:30 PM, it was confirmed that the resident did not have a rise alarm in place for approximately six weeks; from the time the Resident was transferred within the facility to the Frost long term care unit on 4/15/10, until discharge from the facility after the above mentioned fall.	F 282	It has been explained to staff that we need to provide care in strict accordance with the care plan.  Daily each nursing unit generates a current list of residents with alarms. This list facilitates a nightly check of all residents with alarms.  The nurse manager monitors daily and reports to the DNS weekly.  The DNS receives a weekly audit from the nurse managers. These audits serve as the basis for the DNS to report to the monthly Quality / Safety Committee through February 2011. In February 2011 the Quality / Safety Committee will decide if continued monthly reporting is called for. See Exhibit "B."  In an effort to meet the 8/19/10 date set by your agency we will report the weekly August results at the 8/13/10 Administrator Stand-Up meeting.  <i>FABA POC Accepted 8/17/10 [Signature]</i>	6/3/10  6/2/10  6/2/10  8/6/10  8/13/10	

*[Signature]*  
ADMINISTRATOR

7/30/10

CENTERS FOR LIVING AND REHABILITATION

BENNINGTON, VT

**QUALITY MONITORING TOOL**  
*Transfer Checklist Audit*

**TOPIC:** Unit to Unit resident/patient transfers.

**OBJECTIVE:** To verify unit to unit transfers have been documented according to facility policy.

**RECEIVING**

**UNIT:** \_\_\_\_\_

**ROOM #:** \_\_\_\_\_

**DATE:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**TIME:** \_\_\_\_\_

**RECEIVING UNIT NURSE MANAGER INITIALS:** \_\_\_\_\_

CRITERIA	# Opportunities	# Documented
1. Complete documentation of unit to unit transfers in ECS.		
2. Safety devices (if applicable) accompanied patient/resident to unit of transfer.		
% in Compliance =		
Of those not documented, provide action/remediation given:		

CENTERS FOR LIVING AND REHABILITATION

BENNINGTON, VT

**QUALITY MONITORING TOOL**  
*Safety Device Audit*

**TOPIC:** Safety device checks.

**OBJECTIVE:** To ensure that safety devices ordered are care planned and physically in place

**UNIT:** \_\_\_\_\_

**DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**TIME:** \_\_\_\_\_

**NURSE MANAGER INITIALS:** \_\_\_\_\_

CRITERIA	# Opportunities	# Documented
1. Safety devices ordered are care planned.		
2. Safety devices ordered are physically in place.		
Of those not documented, provide action/remediation given:		