DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection

HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

January 8, 2019

Ms. Wendy Beatty, Administrator Bennington Health & Rehab 2 Blackberry Lane Bennington, VT 05201-2300

Dear Ms. Beatty:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 12, 2018.** 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



PRINTED: 12/21/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		475027	B. WING _		C 12/12/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/12/2018	
BENNIN	GTON HEALTH & REI	1AR		2 BLACKBERRY LANE		
				BENNINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE COMPLETION	
E 000	Initial Comments		E 00	o F 584		
				No residents were aff	ected	
	An unannounced e	mergency preparedness		by this alleged deficie	nt	
	Licensing and Prote	ted by the Division of ection during the annual		practice.		
		veen 12/9/18 - 12/12/18.				
	There were no regu	latory issues regarding		All residents have the		
	emergency prepare			potential to be affected	ed by	
F 000	INITIAL COMMENT	rs	F 00	0 this alleged deficient		
	•			practice.		
		n-site re-certification survey he Division of Licensing and				
¥7		12/9/18 and 12/12/18. There	∄ ''€	Bathroom exhaust far	0.27420	
	were regulatory find	lings.		been cleaned internal		
F 584	Safe/Clean/Comfor	table/Homelike Environment	F 58	4 externally. Bugs have	been	
SS=E	CFR(s): 483.10(i)(1)-(7)		removed from light fix		
	§483.10(i) Safe Env	vironment		Bedroom closets have	been	
		right to a safe, clean,	1	replaced or repaired.	Two	
	comfortable and ho	melike environment, including		bedroom doors have	been	
	but not limited to re supports for daily liv	ceiving treatment and ving safely.		repaired.		
	The facility must pro	ovido		Staff have been educa	ited on	
	§483.10(i)(1) A safe	e, clean, comfortable, and ent, allowing the resident to		cleaning protocols.		
		onal belongings to the extent		Environmental audits	will	
	possible.			occur weekly x4 then		
		suring that the resident can		monthly x4 to verify		
		ervices safely and that the ne facility maximizes resident		compliance. Results v	vill be	
		does not pose a safety risk.		reported at QAPI.		
	(ii) The facility shall	exercise reasonable care for				
4		e resident's property from loss		Date of correction: Ja	nuary	
	or theft.			11, 2019.		
	§483.10(i)(2) House	ekeeping and maintenance		Posnansible, France	mantal	
	services necessary	to maintain a sanitary, orderly,		Responsible: Environ		
	and comfortable int		f	Manager, HCSG Mana	ger	
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE	

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 "wing 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 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MG0111

Facility ID: 475027

If continuation sheet Page 1 of 19

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	y-mi-				OMB	NO. 0938	3-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTR IG	UCTION		(ХЗ) DATE SUR COMPLETE	
		475027	B. WING_				***************************************	C 12/12/20	18
NAME OF F	PROVIDER OR SUPPLIER			STREET ADI	DRESS, CITY, STATI	E, ZIP COD)E		
DEALNING				2 BLACKBE	ERRY LANE			\$0	
BENNING	GTON HEALTH & REF	IAB		BENNING	TON, VT 05201				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E	PROVIDER'S PLAN ACH CORRECTIVE A SS-REFERENCED T DEFICIE	ACTION SI TO THE AP	HOULD BE	COM	(X5) PLETION IATE
F 584	Continued From pa	ge 1	F 58	14 F584	roc accepted	117/19	BBorteil	en/pmc	
	§483.10(i)(3) Clean in good condition;	bed and bath linens that are							
		e closet space in each pecified in §483.90 (e)(2)(iv);	1		96				
	§483.10(i)(5) Adequevels in all areas;	uate and comfortable lighting		and the second second	a				
	levels. Facilities init	ortable and safe temperature ially certified after October 1, a temperature range of 71 to							
*	sound levels. This REQUIREMENT by: Based on observat	e maintenance of comfortable NT is not met as evidenced tion and confirmed by staff						8	
	resident's environm	failed to ensure that the sent was maintained to be nelike on both nursing units. e the following:						ě	
	10:26 AM, in the pro Director and the Fir	12/11/18 at approximately esence of the Maintenance e Inspector, resident trooms were identified as		į.					
	to have visible cake -Various bathroom with deceased bugs	ceiling fixtures were identified							
	being rusty/stained	m closets were identified as and in need of cleaning and nce a closet did not have a							

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u>U</u>	MR MO. O	938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPL	
		475027	B. WING	60		C 12/12	/2018
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
BENNING	GTON HEALTH & REI	IAB			LACKBERRY LANE		
				BE	NNINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETION DATE
F 584	Continued From pa	ige 2	F:	584			
	-Two-bedroom doo splintered along the	rs were identified as being e edges, missing pieces of the					
	casing and having	-		3	F 623		
		nade by the Maintenance eaning of the exhaust vents is		1	No residents were af	fected	
		ility with the contracted			by this alleged deficie		
		ices and the maintenance bove identified information was			practice.		
		the Maintenance Director and	1		All residents transfer	red out	
E 623		t the time of the tour. Its Before Transfer/Discharge	E	623	of the facility have th		
	CFR(s): 483.15(c)("	023	potential to be affect		
""		2 5			this alleged deficient		
		nsfers or discharges a	i		practice.		
I	resident, the facility (i) Notify the reside	nt and the resident's			Staff have been edu	cated on	
	representative(s) o	f the transfer or discharge and		1	the notifications neo	essary	
	language and man	move in writing and in a ner they understand. The		1	upon transfer or dis	charge.	
		a copy of the notice to a ne Office of the State			Notification of trans	fer	
	Long-Term Care O				audits will take plac		
	(ii) Record the reas	sons for the transfer or			x4 then monthly x4		
		sident's medical record in			compliance. Result	s will be	
	and	aragraph (c)(2) of this section;			reported at QAPI.		r
	Notice to the second	otice the items described in this section.			Date of correction: 11, 2019.	January	u p
	§483.15(c)(4) Timi						
		fied in paragraphs (c)(4)(ii) and n, the notice of transfer or			Responsible: Busin	ess office	
		under this section must be			Manager.		
	made by the facility resident is transfer	at least 30 days before the			Flaz poc accepted 11	7/19 BBVAEI	i rai Ipme

	to : ott media: "te								
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED		
	€	475027	D MANC				С		
		475027	B. WING			1 12	/12/2018		
NAME OF PROVIDER OR SUPPLIER BENNINGTON HEALTH & REHAB				2 BL	EET ADDRESS, CITY, STATE, ZIP CODE ACKBERRY LANE ININGTON, VT 05201				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 623	Continued From pa	ige 3	F	523					
	be endangered und this section; (B) The health of in be endangered, un this section; (C) The resident's allow a more imme under paragraph (c) (D) An immediate to required by the resunder paragraph (c)	ischarge when- dividuals in the facility would der paragraph (c)(1)(i)(C) of dividuals in the facility would der paragraph (c)(1)(i)(D) of mealth improves sufficiently to diate transfer or discharge, c)(1)(i)(B) of this section; ransfer or discharge is ident's urgent medical needs, c)(1)(i)(A) of this section; or not resided in the facility for 30	i.	The second secon					
	notice specified in must include the formust include the formust include the formust include the formust. The location to transferred or disclipion of including the name and telephone number to obtain an appear completing the formust including the formust including the name and telephone number to obtain an appear completing the formust including the	transfer or discharge; the of transfer or discharge; which the resident is harged; the resident's appeal rights, haddress (mailing and email), hiber of the entity which hests; and information on how how if form and assistance in had submitting the appeal hress (mailing and email) and hof the Office of the State							

PRINTED: 12/21/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			ON	MB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	-	X3) DATE : COMPL	
		475027	B. WING				C 12/1:	2/2018
uels w	PROVIDER OR SUPPLIER GTON HEALTH & REP	HAB		2 BLA	ET ADDRESS, CITY, STATE, ZIP CO ACKBERRY LANE NINGTON, VT 05201	DE .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	۲	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD		(X5) COMPLETION DATE
F 623	developmental disal C of the Developmental and E of the Developmental S o	bilities established under Part ental Disabilities Assistance of of 2000 (Pub. L. 106-402, C. 15001 et seq.); and ility residents with a mental disabilities, the mailing and telephone number of the for the protection and uals with a mental disorder the Protection and Advocacy iduals Act. Inges to the notice. In the notice changes prior to be or or discharge, the facility cipients of the notice as soon the updated information	F 6	23				
	In the case of facilithe administrator of written notification provided to the State Survey State Long-Term Countries the facility, and the well as the plan for relocation of the reseast of the facility. This REQUIREMED by: Based on interview failed to notify the representative in writing for 9 (nine) of 9 approximately and 36. Also, the state of the st	te in advance of facility closure by closure, the individual who is if the facility must provide prior to the impending closure. Agency, the Office of the are Ombudsman, residents of resident representatives, as the transfer and adequate sidents, as required at § NT is not met as evidenced of and record review the facility esident and/or resident's riting of a transfer/discharge plicable residents in the #66, 167, 28, 52, 48, 46, 49, we notice fails to meet ding the contents of the notice						

as per federal and state requirements. Findings

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					OMB NO	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION	_		TE SURVEY MPLETED
		475027	B. WING			connecte.		C /12/2018
NAME OF F	PROVIDER OR SUPPLIER	39		STREE	ET ADDRESS, CITY, ST	ATE, ZIP CODE		
BENNING	STON HEALTH & REP	IAB	*		CKBERRY LANE NINGTON, VT 0520	01		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCE		LD BE	(X5) COMPLETION DATE
F 623	167, 28, 52, 48, 46, transferred to the e and there was no e given in writing to the resident's represendischarge. Per intewith Business Officitransfer notices are s/he was not aware notice to the family with the administration 12/12/18, s/he contification were not	ge 5 al records for Residents #66, 49, 67 and 36 and been mergency room or the hospital vidence of notification being ne resident and/or the tative of the transfer or rview on 12/12/18 8:10 AM e manager, she confirmed that not given and /she said that of the need to give a transfer or resident. In an interview or at approximately 8:30 AM onfirmed that transfer notice t meeting requirements, but ng them correctly as of today.	F 62	23				
	transferred to the a medical evaluation 8/25/18. Per review Resident #28, there transfer/discharge in the resident and/or Confirmation was in Home Administrato 12/11/18 at approxition transfer and discharge provided at the time. The contents of the required elements prequirements listed	w Resident #28 was cute hospital on 8/23/18 for and returned to the facility on w of the medical record for a is no evidence that a notice was sent in writing to the resident's representative. Indicate the Licensed Nursing of and the Office Manager on mately 2:15 PM that the rege written notice was not a of transfer/discharge. Inotice shall contain specific per Federal (CMS) in this regulation. Since the ided the information was not						

available to the resident and/or representative. Also, State requirements regarding the notice are

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	,			CIVID INC	J. 0930-039 I
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		ATE SURVEY OMPLETED
		475027	B. WING			1 1:	C 2/12/2018
	PROVIDER OR SUPPLIER	- COLUMN	I	STRE 2 BL BEN	1 12/12/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLÂN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 623	Continued From pa not met (see F999	-	F	623		75	
	transferred to the a medical evaluation 10/19/18. The resi the hospital on 10/1 medical record for evidence that a tra	ew Resident #66 was acute hospital on 10/16/18 for and returned to the facility on dent was again transferred to 22/18. Per review of the Resident #66, there is no nsfer/discharge notice was e resident and/or the resident's		produces			
	Home Administrate 12/11/18 at approx						
	required elements requirements listed notice was not pro available to the results. State require not met (see 9999 4. Per record reviet transferred to the loccasions; 10/22/1 evidence in the met transfer/discharge	w Resident #52 was nospital on two separate 18 and 10/26/18. There was no edical record that a notice was given to the sident's representative upon					
1	transferred to the no evidence in the transfer/discharge	ew Resident #167 was hospital on 12/3/18. There was medical record that a notice was given to the sident's representative upon		*	ar and a second		

CENTER	13 FOR WEDICARE	A WEDICAID SERVICES	T		CIND	140. 0330-033
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0.0			DATE SURVEY COMPLETED
		475027	B. WING		223	C 12/12/2018
NAME OF F	PROVIDER OR SUPPLIER	1		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	12/12/2010
1000000		-			ACKBERRY LANE	
BENNING	GTON HEALTH & REI	HAB		BEN	NNINGTON, VT 05201	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION E DATE
E 622	ON	7	F.0	00		
F 023	Continued From pa	1 000	F6	23	350	
	transfer/discharge.					
	Per interview on 12	2/11/18 at approximately 2:15			F 625	
		istrator, s/he stated that s/he			1 025	
		a transfer/discharge notice was			No residents were affecte	d
		esident and/or resident's	1		by this alleged deficient	
		n transfer/discharge; and facility was not doing this.			practice.	
	committee that the	racinty was not doing this.			p .co.co.	
		r and Discharge, 3.14 [(d) &			All residents transferred o	out
		Licensing and Operating			of the facility have the	
E 00E	Rules for Nursing I		Г.	ne	potential to be affected by	У
F 625	CFR(s): 483.15(d)	Policy Before/Upon Trnsfr	F6	25	this alleged deficient	
33-0	0111(3). 400.10(0)	(1)(2)			practice.	156
	§483.15(d) Notice	of bed-hold policy and return-			p. court.	
	D. 100 454 W. 41 51 11			1	Staff have been educated	on
		ce before transfer. Before a sfers a resident to a hospital or		1	the notifications necessar	γ
		on therapeutic leave, the		î	upon transfer or discharge	e.
		st provide written information to		4		
		dent representative that			Notification of transfer	
	specifies-				audits will take place wee	ekly
		the state bed-hold policy, if the resident is permitted to			x4 then monthly x4 to ver	rify
		residence in the nursing			compliance. Results will I	be
	facility;	-			reported at QAPI.	
	(ii) The reserve be	d payment policy in the state			395 E	
		40 of this chapter, if any;			Date of correction: Janua	ary
		cility's policies regarding which must be consistent with			11, 2019.	
		f this section, permitting a			Responsible: Business of	fice
	resident to return;	and			(A)	iice
		n specified in paragraph (e)(1)			Manager.	
	of this section.				Flas Poc accepted 1/7/19 BBW	denada
	§483.15(d)(2) Bed	-hold notice upon transfer. At			The state of the s	THI FILL
	the time of transfer					

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION		E SURVEY IPLETED
×		475027	B. WING			1	C 12/2018
	PROVIDER OR SUPPLIER	IAB		2 BL	ET ADDRESS, CITY, STATE, ZIP CODE ACKBERRY LANE NINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 625	facility must provide resident represental specifies the duration described in paragrathis REQUIREMENT by: Based on interview failed to notify their representative in w (nine) of 9 applicable Residents #66, 167, 36. Findings included to 12/12/18 8:10 AM in manager, Nancy Babed hold form is do go to the hospital arise if a bed hold is need family and it is not administrator also degarding bed hold until they were made to the earth of the earth	erapeutic leave, a nursing to to the resident and the stive written notice which on of the bed-hold policy raph (d)(1) of this section. Note is not met as evidenced or and record review the facility esident and/or resident's riting of the bed hold policies 9 are residents in the sample, 17, 28, 52, 48, 46, 49, 67 and a call is placed to the family ded, but it is not given to the assually given in writing. The confirmed that the regulations notification has not been done are aware of the regulation frecords for Residents #66, 149, 67 and 36 and been mergency room or the hospital vidence of notification of a bed writing to the resident and/or esentative.	F	525			
	Per review of the m #28, a Bed Hold No	nedical record for Resident of Policy and			ě		

Authorization form was partially completed by the

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	,			OMB N	O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MUL A. BUILD	TIPLE C		ATE SURVEY OMPLETED	
		475027	B. WING			1	C 2/12/2018
	PROVIDER OR SUPPLIER GTON HEALTH & REP	HAB	,	2 BL	ET ADDRESS, CITY, STATE, ZIP CODE ACKBERRY LANE NINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 625	documented evider resident's represen required informatio bed nor is there an	on 8/23/18. There is no noce that the resident and/or the tative was provided with the n, that they chose to hold the y progress notes by the facility communication that	F	625			
	Home Administrator Manager on 12/11/ that at the time of a hold notice/policy a private pay residen transfer/discharge manager will conta as soon as possible hold the bed. Cont LNHA and the man document the conv they do not provide the notice and all re provided in the bed	nade by the Licensed Nursing or (LNHA) and the Office 18 at approximately 2:15 PM, an unplanned discharge, a bed authorization is provided to the t/representative. If the occurs on off hours the office of the resident/representative is to question if they choose to firmation is made by both the ager that they do not rersation in the medical record, is Medicare/Medicaid residents equired information is not I hold policy. The LNHA is that s/he was unaware of the	Toward Management Company	** ** ** ** ** ** ** ** ** ** ** ** **			
×	transferred to the a medical evaluation	ew Resident #66 was acute hospital on 10/16/18 for and returned to the facility on dent was again transferred to 22/18.		tu .			
	#66, a Bed Hold Notice form was partially of Practical Nurse on	nedical record for Resident office of Policy & Authorization completed by the Licensed 10/16/18 and 10/22/18. There evidence that the resident				BNI	

and/or the resident's representative was provided

with the required information, that the

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	,		O	MB NO	. 0938-0391
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY IPLETED
		475027	B. WING	***************************************		1	C 12/2018
NAME OF F	PROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				2 B	BLACKBERRY LANE		**
BENNING	GTON HEALTH & REF	IAB		BE	ENNINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	Continued From pa	ge 10	F	, 525			
	150 3	itive chose to hold the bed nor		<i>3</i> 23			
		ss notes by the facility staff	9	i			
	identifying any com	munication that transpired.					
	Confirmation was n	nade by the Licensed Nursing			90.		
		r (LNHA) and the Office		1			
		18 at approximately 2:15 PM,					
24		in unplanned discharge a bed					
		uthorization is provided to the		8			
		Vrepresentative. If the					
		occurs on off hours the office					
		ct the resident/representative e to question if they choose to	G&X				
į		irmation is made by both the					
		ager that they do not					
		ersation in the medical record,					
		Medicare/Medicaid residents					
		equired information is not					
		hold policy. The LNHA that s/he was unaware of the					
	requirement.	that one was unaware of the					
		ed Holds (manual titled					1
		le Policies and Procedures) 1/1/18, identifies that when a					
	resident is transferr	ed to a hospital, the designee				199	
		dent/resident representative			*		
		Hold Policy Notice &					
		regardless of payer. If the					
		tive is not present to receive					
		pon transfer, the notice is or hard copy via mail.					
	Genvered via ciriali	or hard copy via IIIall.					
	2. Donner '	Did1 #50					
		v Resident #52 was ospital on two separate					
		8 and 10/26/18. There was no					

evidence that the bed hold notice contained the

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	·		V	ND NO. 0930-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 * *	PLE CONST G		(X3) DATE SURVEY COMPLETED
		475027	B. WING			· C 12/12/2018
NAME OF F	ROVIDER OR SUPPLIER		<u> </u>	CTDEET A	DDRESS, CITY, STATE, ZIP CODE	12/12/2010
9 9630 000		14.5			BERRY LANE	
BENNING	STON HEALTH & REF	1AB		BENNING	GTON, VT 05201	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO EACH CORRECTIVE ACTION SHOULD COSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 625	Continued From pa	age 11	F 62	25		
		hold and that the resident				
		presentative had been notified			F695	- 4
					No residents were affect	·ad
		w Resident #167 was			by this alleged deficient	.cu
		ospital on 12/3/18. There was e bed hold notice contained			practice.	
		bed hold and that the resident			practice.	
		presentative had been notified			All residents who use ox	vgen
	of the bed hold in w	vriting.			concentrators have the	, 0
	Per interview on 12	1/11/18 at approximately 2:15			potential to be affected I	ov
		istrator, s/he confirmed that			this alleged deficient	
2.		nce that the residents' and/or s's had received a bed hold			practice.	
		r to the hospital; and that the			Concentrators for resider	nt
E 605		he duration of the bed holds. costomy Care and Suctioning	F 69	5	#28, 40 and 167 were	
	CFR(s): 483.25(i)	ostomy care and Suctioning	1 08	7 5 [cleaned. Staff was educa	ted
					on the Respiratory	
,		ntory care, including and tracheal suctioning.			Equipment	
	The facility must er	sure that a resident who			Disinfection/Cleaning pol	icy.
		care, including tracheostomy suctioning, is provided such			Audits of concentrators w	/ill
	care, consistent wil	th professional standards of			occur weekly x4, then	
		rehensive person-centered			monthly x4 to verify	
	and 483.65 of this	lents' goals and preferences, subpart.			compliance. Results will I	ne.
-		NT is not met as evidenced			reported to QAPI.	
	by:	tion, confirmed by staff				
		d review, the facility failed to			Compliance date: Januar	y
	provide specialty ca	are needs for the provisions of			11, 2019.	
		6 applicable residents 28, #40, #61, #49 and #317).			Responsible: Nurse	
	The findings includ				Managers	
					F695 POL accepted 1/7/19	BBOTEIL RN/ PNW

CENTE	42 FOR MEDICARE	& MEDICAID SERVICES	,		OI	MB NO.	0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		475027	B. WING				0	
NAME OF I	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	121	12/2018	
DEMINIATE WATER TO SERVICE TO SER				CKBERRY LANE				
BENNING	STON HEALTH & REF	IAB			NINGTON, VT 05201			
(YA) ID	SUMMARY STA	TEMENT OF DEFICIENCIES						
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 695	Continued From pa	ge 12	F6	195				
		on 12/10 and 12/11/18 in the		-				
	presence of the Uni	t Manager, confirmation was			F 993			
	made the filters on	Oxygen concentrators, (that			F 883			
	are in use for Residents #28, #40 and #167), are visibly caked with dust.				No residents were affe	cted		
		cility policy titled Respiratory			by this alleged deficien	d .		
	Equipment Disinfection/Cleaning dated as revised				practice.	- achielle		
	on 3/1/12, identifies oxygen concentrators are to			p		4		
	have the external filter rinsed and dried weekly				All residents who have	ents who have not		
	and as necessary w	hen visibly dusty.			received the flu vaccine			
	2 \ Per observation	on 12/11/19 the filters for the			the potential to be affe			
	2.) Per observation on 12/11/18, the filters for the oxygen concentrators for Residents # 61,49, 317 were heavily soiled with dust. There are physician			*	by this alleged deficien			
						£.		
	orders to clean filter on oxygen concentrator weekly every day shift every Sunday. The Unit Manager for the second floor confirmed the above on 12/11/18 at 11:05 A.M.			practice.				
				Resident # 16, 32 and 4	6			
				have received their flu	U			
E 883			-			w 1901		
	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)		F 8	83	vaccine or documentati			
00-L	O1 11(0). 400.00(u)(1(2)			in place as to why it wa	s not		
	§483.80(d) Influenza	a and pneumococcal			received.			
	immunizations				All registers 53 sp.			
	§483.80(d)(1) Influe	nza. The facility must develop			All resident EMR's will b	ie		
	policies and procedu	ures to ensure that- e influenza immunization,			audited for flu vaccine			
	each resident or the	resident's representative			administration and		Úr	
	each resident or the resident's representative receives education regarding the benefits and				documentation as per p	olicy.		
	potential side effects	of the immunization:			Results will be reported			
	(ii) Each resident is	offered an influenza			QAPI.		ł l	
	immunization Octob	er 1 through March 31						
	contraindicated or #	immunization is medically			Date of correction: Janu	uary		
	immunized during th	ne resident has already been			11, 2019.			
	(iii) The resident or t	he resident's representative						
	has the opportunity	to refuse immunization; and			Responsible: Nurse Edu	cator		
	(iv)The resident's m	edical record includes indicates, at a minimum, the			F883 POC accepted 1/7/19 BBW	Teil PN / PV	m_	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 6	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		475027	B. WING _	3	C 12/12/2018		
NAME OF PROVIDER OR SUPPLIER BENNINGTON HEALTH & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 2 BLACKBERRY LANE BENNINGTON, VT 05201			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L	TION (X5) JLD BE COMPLETION OPRIATE DATE					
F 883	was provided educe and potential side of immunization; and (B) That the reside immunization or did immunization due to refusal. §483.80(d)(2) Pneumust develop policitate (i) Before offering to immunization, each representative receivements and potential munization; (ii) Each resident is immunization; (iii) Each resident is immunization, unle medically contrained already been immunication that the opportunity (iv) The resident or has the opportunity (iv) The resident or has the opportunity (iv) That the reside was provided educe and potential side of immunization; and (B) That the reside pneumococcal immunication or This REQUIREME by: Based on interviewed.	Int or resident's representative ation regarding the benefits effects of influenza and either received the influenza at not receive the influenza at mot receive and procedures. The facility ies and procedures to ensure the pneumococcal are resident or the resident's eives education regarding the stial side effects of the soffered a pneumococcal as the immunization is dicated or the resident has unized; the resident's representative at the received indicates, at a minimum, the int or resident's representative ation regarding the benefits effects of pneumococcal and either received the nunization or did not receive immunization due to medical	F 8	83			

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO	MB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		ATE SURVEY OMPLETED
		475027	B. WING			1	C 2/12/2018
NAME OF PROVIDER OR SUPPLIER BENNINGTON HEALTH & REHAB			2 B	REET ADDRESS, CITY, STATE, ZIP CODE BLACKBERRY LANE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 883	ensure that resident documentation that and/or resident's re education regarding side effects of influe the residents either immunization or dic immunization due to refusal for 3 of 6 ap #16, Resident #32, include: 1. Per record review to the facility on 5/9 given the influenza was no evidence in resident and/or resiprovided education potential side effect and whether or not vaccine and/or had the reasons why. 2. Per record review to the facility on 8/8 given the influenza was no evidence in resident and/or resiprovided education potential side effect and whether or not vaccine and/or had the reasons why.	its' medical records included indicated that the resident presentative was provided to the benefits and potential enza immunizations; and that received the influenza of medical contraindications or oplicable residents (Resident and Resident #46). Findings of Resident #46. The resident was last vaccine on 11/13/17. There is the medical record that the ident's representative was regarding the benefits and the resident had received the not received the vaccine; and of Resident #32 was admitted of 14. The resident was last vaccine on 11/13/17. There is the medical record that the ident's representative was regarding the benefits and the office of influenza immunizations; the resident had received the not received the vaccine; and	F8	883			
	to the facility on 1/3	w Resident #46 was admitted 31/18. There was no evidence and that the resident had					

received and/or had not received the influenza vaccine; and the reasons why; and that the

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO	0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		ONSTRUCTION		TE SURVEY MPLETED
		475027	B. WING			12	C 2/12/2018
	PROVIDER OR SUPPLIER	1AB		2 BLA	ET ADDRESS, CITY, STATE, ZIP CODE ACKBERRY LANE NINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 883	provided education	age 15 ident's representative was regarding the benefits and ts of influenza immunizations.	·F 8	83		73	·
F9999	Nurse Practice Edunone of these above influenza vaccine for confirmed that their their medical record or had not received the residents' and/or provided education potential side effect Per review of the planting limited provided the planting potential side effect Per review of the planting the Action Plant to perform the Action Plant to perform the Action Plant to perform the planting limited provide information benefit of immunization in provide information in performance immunization in Potential Physician/provider decision maker's refinal OBSERVAT		F99	999	F9999 No residents were affected by this alleged deficient practice. Past non-compliance for staffing documentation. Staffing coordinator has been educated on the state regulation regarding daily staffing requirements. Audits of daily staffing will take place weekly x4 then monthly x4. Results will be reported to QAPI. Date of compliance: Janua 11, 2019 Responsible: CNE and Staffing coordinator.	2	
	the facility failed to adequate to meet r	rd review and staff interview, maintain staffing levels resident needs as required by ensing Regulations. Findings			Staffing coordinator.		0.00

include:

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391					
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10.00 BEX		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		475027	B. WING			C 12/12/2018			
NAME OF PROVIDER OR SUPPLIER BENNINGTON HEALTH & REHAB			2	TREET ADDRESS, CITY, STATE, ZIP CODE BLACKBERRY LANE ENNINGTON, VT 05201					
- (X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION			
F9999	minimum, nursing fewer than 3 (three resident per day, or nursing care, personursing care, but no supervision of staff direct care, no fewer resident per day mustandard LNA (Lice (such as personal cambulation, feeding equivalent staff and preparation, physic program. This REQUIREMED by: Review of staffing to 12/10/18 presented 7 (seven) days below there were a total of November there were below the required Confirmation was rescheduler on 12/13 AM, that the hours hours even with the staff providing care 2. The following vicand Operating Rule	on 7.13 d. 1. i requires at a racilities must provide: no) hours of direct care per n a weekly average, including and care and restorative of including administration or ; and of the 3 (three) hours of er than 2 (two) hours per ust be assigned to provide ensed Nursing Assistant) care care, assistance with g, etc.) performed by LNAs or d not including meal all therapy or the activities NT is NOT MET as evidenced that in September there were ow the required number of 2.0 that in Care, October noted that of 17 (seventeen) days and in as 9 (nine) days that were number of hours. The series of the required inclusion of other qualified expenses for Nursing Homes were	F99	999	F99999 No residents were affected by this alleged deficient practice. All residents transferred out of the facility have the potential to be affected by this alleged deficient practice. Staff have been educated of the notifications necessary upon transfer or discharge. Notification of transfer audits will take place week x4 then monthly x4 to verific compliance. Results will be reported at QAPI. Date of correction: January 11, 2019. Responsible: Business office	on ly fy e			
	and Operating Rule identified in relation	es for Nursing Homes were			Responsible: Business office Manager.	ce			

3.14 Transfer and Discharge

F9999 POL accepted 1/7/19 EBINTEIL PN/ PML

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CENTER	(2 LOK MEDICAKE	& MEDICAID SERVICES				IND NO	. 0530-0351	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		475027	B. WING			1	C /12/2018	
NAME OF F	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
				2 BLA	ACKBERRY LANE			
BENNINGTON HEALTH & REHAB				BEN	NINGTON, VT 05201			
	CHMMADV CTA	TEMENT OF DEFICIENCIES	ı.		PROVIDER'S PLAN OF CORRECTION	BDECTION		
(X4) ID PREFIX TAG			ID PREF TAG		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F9999	Continued From pa	ae 17	F99	999				
	*	nts of the notice. The written	(A) (A)					
		his subsection shall be on a						
		e licensing agency or one that						
		ilar and must include the						
	following:							
		 the reason for transfer or discharge; 						
	(2) the effective date of transfer or discharge;(3) the location to which the resident is being transferred or discharged;(4) a statement in large print or large point type							
		is the right to appeal the						
		transfer or discharge to the						
		ropriate information regarding		1				
		t forth in 3.14 (h) below;		ļ				
	(5) the name, addre	ess and telephone number of						
		m Care Ombudsman;						
		t the resident may remain in						
	place pending the				8			
	(7) for nursing facil	ity residents with abilities, the mailing address						
		ber of the Developmental						
		ect and that of the Vermont					S	
		elopmental and Mental Health						
		of Developmental Services;			8			
	and/or							
(8) for nursing facility residents who are mentally ill, the mailing address and telephone number of Vermont Protection and Advocacy, Inc.								
		NT is NOT MET as evidenced			ec.			
	by: -							
	Pacad on record as	wious and confirmed by staff						
		eview and confirmed by staff y failed to provide a written						
		ischarge at the time of transfer						
		9 of 9 applicable residents,	- 8		5			
		7, 28, 52, 48, 46, 49, 67 and						

36). The findings include the following:

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	·			U	NIP NO.	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED C	
i .		475027	B. WING				1	2/2018
NAME OF F	ROVIDER OR SUPPLIER	<u> </u>		STRE	ET ADDRESS, CITY, STATE, ZIP CO	DE		
BENNING	STON HEALTH & REI	IAB			ACKBERRY LANE NINGTON, VT 05201			
	CUMMADV CTA	TEMENT OF DEFICIENCIES		DLIVI	PROVIDER'S PLAN OF COR	DECTIO	u .	,VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F9999	Home Administrato 12/11/18 at approxi transfer/discharge	nade by the Licensed Nursing or and the Office Manager on imately 2:15 PM that a written notice has not been e of transfer/discharge for any	F99	999		r		-
1								
				ş				
			2					
					*			
			1.0					
		•						116