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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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
E 000	Initial Comments An unannounced emergency preparedness review was conducted by the Division of Licensing and Protection during the annual re-certification between 12/9/18 - 12/12/18. There were no regulatory issues regarding emergency preparedness at this time.	E 000	F 584 No residents were affected by this alleged deficient practice. All residents have the potential to be affected by this alleged deficient practice. Bathroom exhaust fans have been cleaned internally and externally. Bugs have been removed from light fixtures. Bedroom closets have been replaced or repaired. Two bedroom doors have been repaired. Staff have been educated on cleaning protocols. Environmental audits will occur weekly x4 then monthly x4 to verify compliance. Results will be reported at QAPI. Date of correction: January 11, 2019. Responsible: Environmental Manager, HCSG Manager	
F 000	INITIAL COMMENTS An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection between 12/9/18 and 12/12/18. There were regulatory findings.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	12.26.18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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 584	Continued From page 1	F 584	F584 POC accepted 1/7/19 BBartell RN/PMC	

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation and confirmed by staff interview the facility failed to ensure that the resident's environment was maintained to be clean, safe and homelike on both nursing units. The findings include the following:

Per facility tour on 12/11/18 at approximately 10:26 AM, in the presence of the Maintenance Director and the Fire Inspector, resident bathrooms and bedrooms were identified as follows:

-Multiple bathroom exhaust vents were identified to have visible caked dust present;
-Various bathroom ceiling fixtures were identified with deceased bugs;
-Numerous bedroom closets were identified as being rusty/stained and in need of cleaning and repair. In one instance a closet did not have a door present;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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 584 Continued From page 2

-Two-bedroom doors were identified as being splintered along the edges, missing pieces of the casing and having loose door hinges.

Confirmation was made by the Maintenance Director that the cleaning of the exhaust vents is a shared responsibility with the contracted housekeeping services and the maintenance department. The above identified information was confirmed by both the Maintenance Director and the Fire Marshall at the time of the tour.

F 584

F 623 SS=C Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable

F 623

F 623

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 on the notifications necessary upon transfer or discharge.

Notification of transfer audits will take place weekly x4 then monthly x4 to verify compliance. Results will be reported at QAPI.

Date of correction: January 11, 2019.

Responsible: Business office Manager.

F623 POC accepted 1/7/19 BB/RN/PMC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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 623	Continued From page 3	F 623		

before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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 623	Continued From page 4	F 623		

developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to notify the resident and/or resident's representative in writing of a transfer/discharge for 9 (nine) of 9 applicable residents in the sample, Residents #66, 167, 28, 52, 48, 46, 49, 67 and 36. Also, the notice fails to meet requirements regarding the contents of the notice as per federal and state requirements. Findings

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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 623	Continued From page 5	F 623		

include:

1. Review of medical records for Residents #66, 167, 28, 52, 48, 46, 49, 67 and 36 and been transferred to the emergency room or the hospital and there was no evidence of notification being given in writing to the resident and/or the resident's representative of the transfer or discharge. Per interview on 12/12/18 8:10 AM with Business Office manager, she confirmed that transfer notices are not given and /she said that s/he was not aware of the need to give a transfer notice to the family or resident. In an interview with the administrator at approximately 8:30 AM on 12/12/18, s/he confirmed that transfer notice notification were not meeting requirements, but they have been doing them correctly as of today.

2. Per record review Resident #28 was transferred to the acute hospital on 8/23/18 for medical evaluation and returned to the facility on 8/25/18. Per review of the medical record for Resident #28, there is no evidence that a transfer/discharge notice was sent in writing to the resident and/or the resident's representative.

Confirmation was made by the Licensed Nursing Home Administrator and the Office Manager on 12/11/18 at approximately 2:15 PM that the transfer and discharge written notice was not provided at the time of transfer/discharge.

The contents of the notice shall contain specific required elements per Federal (CMS) requirements listed in this regulation. Since the notice was not provided the information was not available to the resident and/or representative. Also, State requirements regarding the notice are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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 623	Continued From page 6	F 623		

not met (see F9999).

3. Per record review Resident #66 was transferred to the acute hospital on 10/16/18 for medical evaluation and returned to the facility on 10/19/18. The resident was again transferred to the hospital on 10/22/18. Per review of the medical record for Resident #66, there is no evidence that a transfer/discharge notice was sent in writing to the resident and/or the resident's representative.

Confirmation was made by the Licensed Nursing Home Administrator and the Office Manager on 12/11/18 at approximately 2:15 PM that the transfer and discharge written notice was not provided at the time of either of the transfers/discharges.

The contents of the notice shall contain specific required elements per Federal (CMS) requirements listed in this regulation. Since the notice was not provided the information was not available to the resident and/or representative. Also, State requirements regarding the notice are not met (see 9999).

4. Per record review Resident #52 was transferred to the hospital on two separate occasions; 10/22/18 and 10/26/18. There was no evidence in the medical record that a transfer/discharge notice was given to the resident and/or resident's representative upon transfer/discharge.

5. Per record review Resident #167 was transferred to the hospital on 12/3/18. There was no evidence in the medical record that a transfer/discharge notice was given to the resident and/or resident's representative upon

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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 623	Continued From page 7 transfer/discharge. Per interview on 12/11/18 at approximately 2:15 PM with the Administrator, s/he stated that s/he was unaware that a transfer/discharge notice was to be given to the resident and/or resident's representative upon transfer/discharge; and confirmed that the facility was not doing this. (See 9999 Transfer and Discharge, 3.14 [(d) & (e)] of the Vermont Licensing and Operating Rules for Nursing Homes)	F 623		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for	F 625	F 625 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 on the notifications necessary upon transfer or discharge. Notification of transfer audits will take place weekly x4 then monthly x4 to verify compliance. Results will be reported at QAPI. Date of correction: January 11, 2019. Responsible: Business office Manager. F625 POC accepted 1/7/19 BBurtell RN/PMC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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 625	Continued From page 8	F 625		

hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to notify the resident and/or resident's representative in writing of the bed hold policies 9 (nine) of 9 applicable residents in the sample, Residents #66, 167, 28, 52, 48, 46, 49, 67 and 36. Findings include:

12/12/18 8:10 AM interview with Business Office manager, Nancy Bartlett, she confirmed that a bed hold form is done and given to the resident to go to the hospital and a call is placed to the family if a bed hold is needed, but it is not given to the family and it is not usually given in writing. The administrator also confirmed that the regulations regarding bed hold notification has not been done until they were made aware of the regulation today.
Review of medical records for Residents #66, 167, 28, 52, 48, 46, 49, 67 and 36 and been transferred to the emergency room or the hospital and there was no evidence of notification of a bed hold was given in writing to the resident and/or the resident's representative.

1. Per record review Resident #28 was transferred to the acute hospital on 8/23/18 for medical evaluation and returned to the facility on 8/25/18.

Per review of the medical record for Resident #28, a Bed Hold Notice of Policy and Authorization form was partially completed by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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 625	Continued From page 9	F 625		

Director of Nurses on 8/23/18. There is no documented evidence that the resident and/or the resident's representative was provided with the required information, that they chose to hold the bed nor is there any progress notes by the facility staff identifying any communication that transpired.

Confirmation was made by the Licensed Nursing Home Administrator (LNHA) and the Office Manager on 12/11/18 at approximately 2:15 PM, that at the time of an unplanned discharge, a bed hold notice/policy authorization is provided to the private pay resident/representative. If the transfer/discharge occurs on off hours the office manager will contact the resident/representative as soon as possible to question if they choose to hold the bed. Confirmation is made by both the LNHA and the manager that they do not document the conversation in the medical record, they do not provide Medicare/Medicaid residents the notice and all required information is not provided in the bed hold policy. The LNHA confirms at the time that s/he was unaware of the requirement.

2. Per record review Resident #66 was transferred to the acute hospital on 10/16/18 for medical evaluation and returned to the facility on 10/19/18. The resident was again transferred to the hospital on 10/22/18.

Per review of the medical record for Resident #66, a Bed Hold Notice of Policy & Authorization form was partially completed by the Licensed Practical Nurse on 10/16/18 and 10/22/18. There is no documented evidence that the resident and/or the resident's representative was provided with the required information, that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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 625	Continued From page 10	F 625		

resident/representative chose to hold the bed nor is there any progress notes by the facility staff identifying any communication that transpired.

Confirmation was made by the Licensed Nursing Home Administrator (LNHA) and the Office Manager on 12/11/18 at approximately 2:15 PM, that at the time of an unplanned discharge a bed hold notice/policy authorization is provided to the private pay resident/representative. If the transfer/discharge occurs on off hours the office manager will contact the resident/representative as soon as possible to question if they choose to hold the bed. Confirmation is made by both the LNHA and the manager that they do not document the conversation in the medical record, they do not provide Medicare/Medicaid residents the notice and all required information is not provided in the bed hold policy. The LNHA confirms at the time that s/he was unaware of the requirement.

Per review of the Bed Holds (manual titled Accounts Receivable Policies and Procedures) dated as revised on 1/1/18, identifies that when a resident is transferred to a hospital, the designee will provide the resident/resident representative with the written Bed Hold Policy Notice & Authorization form regardless of payer. If the resident representative is not present to receive the written notice upon transfer, the notice is delivered via email or hard copy via mail.

3. Per record review Resident #52 was transferred to the hospital on two separate occasions; 10/22/18 and 10/26/18. There was no evidence that the bed hold notice contained the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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 625	Continued From page 11 duration of the bed hold and that the resident and/or resident's representative had been notified of the bed hold in writing. 4. Per record review Resident #167 was transferred to the hospital on 12/3/18. There was no evidence that the bed hold notice contained the duration of the bed hold and that the resident and/or resident's representative had been notified of the bed hold in writing. Per interview on 12/11/18 at approximately 2:15 PM with the Administrator, s/he confirmed that there was no evidence that the residents' and/or their representative's had received a bed hold notice upon transfer to the hospital; and that the notices contained the duration of the bed holds.	F 625	F695 No residents were affected by this alleged deficient practice. All residents who use oxygen concentrators have the potential to be affected by this alleged deficient practice. Concentrators for resident #28, 40 and 167 were cleaned. Staff was educated on the Respiratory Equipment Disinfection/Cleaning policy. Audits of concentrators will occur weekly x4, then monthly x4 to verify compliance. Results will be reported to QAPI. Compliance date: January 11, 2019. Responsible: Nurse Managers F695 POC accepted 1/7/19 BBartell RN/PMC	
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, confirmed by staff interview and record review, the facility failed to provide specialty care needs for the provisions of respiratory care for 6 applicable residents (Resident # 167, #28, #40, #61, #49 and #317). The findings include the following:	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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 695	Continued From page 12 1.) Per facility tour on 12/10 and 12/11/18 in the presence of the Unit Manager, confirmation was made the filters on Oxygen concentrators, (that are in use for Residents #28, #40 and #167), are visibly caked with dust. Per review of the facility policy titled Respiratory Equipment Disinfection/Cleaning dated as revised on 3/1/12, identifies oxygen concentrators are to have the external filter rinsed and dried weekly and as necessary when visibly dusty. 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 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.	F 695	F 883 No residents were affected by this alleged deficient practice. All residents who have not received the flu vaccine have the potential to be affected by this alleged deficient practice. Resident # 16, 32 and 46 have received their flu vaccine or documentation is in place as to why it was not received. All resident EMR's will be audited for flu vaccine administration and documentation as per policy. Results will be reported at QAPI. Date of correction: January 11, 2019. Responsible: Nurse Educator F883 POC accepted 1/7/19 BBurrell RN/PMC	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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 883	Continued From page 13	F 883		

following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to follow their policies and procedures to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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 883	Continued From page 14	F 883		

ensure that residents' medical records included documentation that indicated that the resident and/or resident's representative was provided education regarding the benefits and potential side effects of influenza immunizations; and that the residents either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal for 3 of 6 applicable residents (Resident #16, Resident #32, and Resident #46). Findings include:

1. Per record review Resident #16 was admitted to the facility on 5/9/14. The resident was last given the influenza vaccine on 11/13/17. There was no evidence in the medical record that the resident and/or resident's representative was provided education regarding the benefits and potential side effects of influenza immunizations; and whether or not the resident had received the vaccine and/or had not received the vaccine; and the reasons why.

2. Per record review Resident #32 was admitted to the facility on 8/8/14. The resident was last given the influenza vaccine on 11/13/17. There was no evidence in the medical record that the resident and/or resident's representative was provided education regarding the benefits and potential side effects of influenza immunizations; and whether or not the resident had received the vaccine and/or had not received the vaccine; and the reasons why.

3. Per record review Resident #46 was admitted to the facility on 1/31/18. There was no evidence in the medical record that the resident had received and/or had not received the influenza vaccine; and the reasons why; and that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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 883	Continued From page 15 resident and/or resident's representative was provided education regarding the benefits and potential side effects of influenza immunizations. Per interview on 12/12/18 at 1:06 PM with the Nurse Practice Educator, s/he confirmed that none of these above residents had received the influenza vaccine for the 2018 season. S/he also confirmed that there was nothing documented in their medical records as to why the residents' had or had not received the immunizations; and that the residents' and/or their representatives were provided education regarding the benefits and potential side effects of influenza immunizations. Per review of the policy, "IC600 Influenza Immunization Program, under Process 3. Follow the Action Plan to provide and document education to patient or health care decision maker. 4. If patient/health care decision maker or employee refuses influenza immunization, provide information and counseling regarding the benefit of immunization. 4.1 If immunization refused, document patient's or decision maker's refusal of immunization and education and counseling given regarding the benefit of immunization in Point Click Care (electronic medical record). 4.1.1 Notify attending physician/provider of patient's decision or decision maker's refusal and document".	F 883	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: January 11, 2019 Responsible: CNE and Staffing coordinator.	
F9999	FINAL OBSERVATIONS 1. Based on record review and staff interview, the facility failed to maintain staffing levels adequate to meet resident needs as required by Vermont State Licensing Regulations. Findings include:	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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
F9999	Continued From page 16 Per State Regulation 7.13 d. 1. i requires at a minimum, nursing facilities must provide: no fewer than 3 (three) hours of direct care per resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and of the 3 (three) hours of direct care, no fewer than 2 (two) hours per resident per day must be assigned to provide standard LNA (Licensed Nursing Assistant) care (such as personal care, assistance with ambulation, feeding, etc.) performed by LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program. This REQUIREMENT is NOT MET as evidenced by: Review of staffing hours between 9/1/18 and 12/10/18 presented that in September there were 7 (seven) days below the required number of 2.0 hours of LNA direct care, October noted that there were a total of 17 (seventeen) days and in November there was 9 (nine) days that were below the required number of hours. Confirmation was made by the facility nursing scheduler on 12/13/18 at approximately 10:00 AM, that the hours did not meet the required hours even with the inclusion of other qualified staff providing care. 2. The following violations of Vermont Licensing and Operating Rules for Nursing Homes were identified in relation to the notice of transfer/discharge being used by the facility. 3.14 Transfer and Discharge	F9999	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 on the notifications necessary upon transfer or discharge. Notification of transfer audits will take place weekly x4 then monthly x4 to verify compliance. Results will be reported at QAPI. Date of correction: January 11, 2019. Responsible: Business office Manager. F9999 POC accepted 1/7/19 EBartell RN/PMC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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
F9999	Continued From page 17	F9999		

#1) 3.14 (e) Contents of the notice. The written notice specified in this subsection shall be on a form provided by the licensing agency or one that is substantially similar and must include the following:
(1) 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 that the resident has the right to appeal the facility's decision to transfer or discharge to the State, with the appropriate information regarding how to do so as set forth in 3.14 (h) below;
(5) the name, address and telephone number of the State Long Term Care Ombudsman;
(6) a statement that the resident may remain in place pending the appeal;
(7) for nursing facility residents with developmental disabilities, the mailing address and telephone number of the Developmental Disability Law Project and that of the Vermont Department of Developmental and Mental Health Services, Division of Developmental Services; and/or
(8) for nursing facility residents who are mentally ill, the mailing address and telephone number of Vermont Protection and Advocacy, Inc.

This REQUIREMENT is NOT MET as evidenced by:

Based on record review and confirmed by staff interview the facility failed to provide a written notice of transfer/discharge at the time of transfer to the hospital, for 9 of 9 applicable residents, (Residents #66, 167, 28, 52, 48, 46, 49, 67 and 36). The findings include the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE 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
F9999	Continued From page 18 Confirmation was made by the Licensed Nursing Home Administrator and the Office Manager on 12/11/18 at approximately 2:15 PM that a transfer/discharge written notice has not been provided at the time of transfer/discharge for any of the above listed residents.	F9999		