VERMONT

AGENCY OF HUMAN SERVICES

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 28, 2020

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 **January 8, 2020**. 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

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 _____	01/08/2020

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 The Division of Licensing and Protection conducted an annual emergency preparedness survey on 1/8/2020 and the facility was found to be in compliance with the regulations surrounding emergency preparedness.	E 000		
F 000	INITIAL COMMENTS An unannounced on-site annual re-certification survey was conducted by the Division of Licensing and Protection between 1/6 and 1/8/2020. There were regulatory findings identified during the survey.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure that 1 resident in the applicable sample (Resident #9), received adequate supervision and assistance to prevent accidents while using the whirlpool tub. Findings include: Per record review a nurse note indicates that on 10/24/19, Resident #9 slid off the whirlpool tub chair and hit his/her head. An RMS (Event Summary Report) noted that the resident was tipped over in the tub chair with head resting on	F 689	F689 Accidents Resident #9 was evaluated at the local ER for injury. No other injury noted. All residents who utilize the bath chair have the potential to be affected by this alleged deficient practice. Staff educated on and competencies completed for proper utilization of the bathtub chair. Competency of correct usage of the bath chair added to orientation. A weekly X4 then monthly X3 audit of new hires and current staff usage of the bath chair will occur. Results will be reported to the QAPI committee. Date of compliance: January 28, 2020. Responsible party: NPE, Nurse Manager or Designee F689 POC accepted 1/24/20 BBowker RN/PMC	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 1.26.2020

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days g 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 lowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 689	Continued From page 1	F 689		

tub. Licensed Nursing Assistant (LNA) was bent down next to resident and stated that "the base of bathtub chair didn't connect to the bathtub chair". Resident was alert, talking and complained of head pain, bump noted to back of head and no other injuries noted. The Registered Nurse (RN) was contacted to assess and the resident transferred via hoyer lift (a mechanical lift) to the wheelchair (w/c). The Physician office was contacted and was made aware that the resident was being sent to emergency room (ER) for evaluation.

On 1/7/20 at 3:43 PM, the third floor unit manager indicated that maintenance inspected the tub and it was found to be functioning properly and it was confirmed that the traveler LNA did not connect the chair correctly.

On 01/07/20 at 04:02 PM, per observation and interview, a second shift LNA and the unit manager demonstrated how to operate the tub. The seat needs to be connected to the base at the end of the tub and there are rods that slide into bars located on each side of the inner part of the tub. Per both staff members, on the date of the accident it was discovered that the base was not attached, and the seat rolled forward causing the resident to slide out of the chair and hit his/her head.

On 01/08/20 at 11:11 AM, a telephone interview was conducted with the LNA assigned to Resident #9 the day of the incident. S/he recalls the incident and s/he stated that they had not used a whirlpool tub in many years. S/he stated that s/he is a traveling nursing assistant and had no training on how to use the whirlpool other than being shown how it operated, just prior to the

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F 689 Continued From page 2

incident, by another LNA. S/he further stated that s/he did not feel comfortable but gave the whirlpool because it was part of his/her assignment and there was no other staff with him/her at the time. She further stated that when getting the resident out of the tub, the chair detached and the resident fell forward and hit his/her head.

The Registered Nurse staff educator confirmed on 1/7/20 at 4:12 PM that when travel LNA's are oriented, there is a skills check sheet for the use of mechanical lifts, but stated "there is not one for tub use or other equipment and there are no signature sheets regarding training after the incident, it was only verbal." The RN further stated that s/he does not teach staff the usage of the whirlpool and that it is done by other LNAs that have been working at the facility for a long time, and he confirmed that these LNAs had not been reviewed for competency in the use of the whirlpool.

F 726 Competent Nursing Staff
SS=E CFR(s): 483.35(a)(3)(4)(c)

§483.35 Nursing Services
The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

F 689

F726 Competencies

Resident #9 was evaluated at the local ER for injury. No other injury noted.

All residents who utilize the bath chair have the potential to be affected by this alleged deficient practice.

Staff educated on and competencies completed for proper utilization of the bathtub chair. Competency of correct usage of the bath chair added to orientation.

F 726

A weekly X4 then monthly X3 audit of new hires and current staff usage of the bath chair will occur. Results will be reported to the QAPI committee.

Date of compliance: January 28, 2020.

Responsible party: NPE, Nurse Manager or Designee

F726 POC accepted 1/24/20 BBowerman/RN

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§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to assure that all nursing staff possess the competencies and skill sets necessary to provide safety to residents receiving a whirlpool tub bath. This has the potential to effect any resident of the facility that utilizes the whirlpool tub in addition to Resident #9. Findings include:

Per record review a nurse note indicates that on 10/24/19, Resident #9 slid off the whirlpool tub chair and hit his/her head. A Licensed Nursing Assistant (LNA) was bent down next to resident and stated that "the base of bathtub chair didn't connect to the bathtub chair". On 1/7/20 at 3:43 PM, the third floor unit manager indicated that maintenance inspected the tub and it was found to be functioning properly and it was confirmed that the traveler LNA did not connect the chair correctly.

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On 01/07/20 at 04:02 PM, per observation and interview, a second shift LNA and the unit manager demonstrated how to operate the tub. The seat needs to be connected to the base at the end of the tub and there are rods that slide into bars located on each side of the inner part of the tub. Per both staff members, on the date of the accident it was discovered that the base was not attached, and the seat rolled forward causing the resident to slide out of the chair and hit his/her head.

On 01/08/20 at 11:11 AM, a telephone interview was conducted with the LNA assigned to Resident #9 the day of the incident. S/he recalls the incident and s/he stated that they had not used a whirlpool tub in many years. S/he stated that s/he is a traveling nursing assistant and had no training on how to use the whirlpool other than being shown how it operated, just prior to the incident, by another LNA. S/he further stated that s/he did not feel comfortable but gave the whirlpool because it was part of his/her assignment and there was no other staff with him/her at the time. She further stated that when getting the resident out of the tub, the chair detached and the resident fell forward and hit his/her head.

The Registered Nurse staff educator confirmed on 1/7/20 at 4:12 PM that when travel LNA's are oriented, there is a skills check sheet for the use of mechanical lifts, but stated "there is not one for tub use or other equipment and there are no signature sheets regarding training after the incident, it was only verbal." The RN further stated that s/he does not teach staff the usage of the whirlpool and that it is done by other LNAs

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F 726	Continued From page 5 that have been working at the facility for a long time, and he confirmed that these LNAs had not been reviewed for competency in the use of the whirlpool. There is no evidence found, during the review of competency skills for the LNAs that there has ever been any training to the staff in the use of the whirlpool bath and the ability to demonstrate the ability to competently use the whirlpool and to insure that the chair is securely attached. This was confirmed by the RN staff educator that there is no evidence that there have been training on the whirlpool prior to the incident.	F 726		