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 5, 2021

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 **November 4, 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
Licensing Chief

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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 11/04/2020

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	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite investigation of facility reported incident was conducted by the Division of Licensing and Protection, in conjunction with an anonymous complaint investigation on 10/21-10/22/2020, followed by off-site staff interviews and record reviews on 10/23 - 11/4/2020. There were regulatory findings as a result of these investigations.	F 000	F693 Resident #1 had no negative effects from this alleged deficient practice. All residents who receive enteral nutrition have the potential to be affected by this alleged deficient practice.	
F 693 SS=E	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure that 1 of 4 sampled	F 693	Nurses have been educated on the proper administration of enteral nutrition at the scheduled time and frequency per physicians order. If a scheduled dose is missed or untimely the physician needs to be notified. Audits of the medication administration record will take place weekly X4 then monthly X4 to assure compliance. Results will be reported to the QAPI committee by the DON for four months. Date of Correction: December 12, 2020 Responsible: DON, Nurse Managers	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Executive Dir
(X6) DATE: 12.1.2020

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.

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F 693	Continued From page 1 residents (Resident #1) received their enteral nutrition at the scheduled time and frequency per physician's order. Findings include: Per record review Resident #1 has a diagnoses of dysphagia, requiring him to have a Gastrostomy Tube (G-Tube), (a tube that is inserted through the abdomen that delivers nutrition directly to the stomach). The physicians order states "Enteral Feed Order six times a day related to DYSPHAGIA FOLLOWING OTHER CEREBROVASCULAR DISEASE" "Jevity 1.5 CAL Administer bolus via gravity 237 ML (millimeters) 6 times per day. Administer 110 ML water before and after each feed. Per review of Resident #1's Medication Administration Record (MAR), the scheduled times for the enteral feedings were 7:00 AM, 10:00 AM, 1:00 PM, 4:00 PM, 7:00 PM, and 10:00 PM. Per review of a time stamped MAR, on 9/20/20 the Licensed Practical Nurse (LPN) signed that s/he did not administer the 7:00 PM enteral feeding until 9:47 PM and the 10:00 PM feeding was signed for at 10:27 PM, allowing only 40 minutes between administration. On 9/22/20, the LPN signed that s/he administered the 4:00 PM feeding at 8:53 PM, the 7:00 PM feeding at 9:29 PM and the 10:00 PM feeding at 9:31 PM, indicating that Resident #1 received 3 feedings over 38 minutes. On 9/23/20 the LPN signed that both the 4:00 PM and the 7:00 PM feedings were administered at 9:57 PM and the 10:00 PM feeding was administered at 9:58 PM indicating that all three feedings were given at the same time. On 9/25/20, the LPN signed for the 7:00 PM feeding at 8:35 PM. On 9/26/20 the LPN signed that the 7:00 PM feeding was not administered	F 693	F693 POC accepted 1/5/21 S.Freeman RN/PMC	

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F 693	Continued From page 2 until 8:35 PM. On 9/27/20, the LPN signed that the 4:00 PM dose was administered at 6:37 PM, both the 7:00 PM and 10:00 PM feedings were administered at 10:44 PM. On 9/28/20 the LPN signed for the 7:00 PM feeding at 8:37 PM. On 9/29/20 the LPN signed the 7:00 AM feeding at 8:39 PM. On 9/30/20, the LPN signed that the 4:00 PM feeding was not administered until 5:34 PM and the 7:00 PM feeding was not given until 8:54 PM. On 10/1/20 the LPN signed for the 7:00 PM feeding at 9:06 PM. On 10/2/20 the LPN singed that the 7:00 PM feeding was not administered until 10:19 PM, and the 10:00 PM feeding was signed out at 10:47 PM. On 10/4/2020 the 4:00 PM feeding was not signed for until 6:09 PM and both the 7:00 PM and 10:00 PM feedings were signed for at 9:03 PM. On 10/6/20, the 4:00 PM feeding was signed as administered at 6:35 PM, and the 7:00 PM feeding was signed out at 8:24. On 10/7/20 the 4:00 PM feeding was signed as administered at 8:53 PM and there was no signature indicating that the 10:00 PM feeding was given. On 10/10/20, the 4:00 PM feeding was signed for at 5:40 PM, the 7:00 PM was signed at 9:08 PM, and the 10:00 PM was signed for at 9:09 PM indicating that the 7:00 PM and 10:00 PM feedings were give at the same time. Per review of the facility Medication Errors policy an example of an "Administration time error- Center staff administer to the patient a medication dose greater than 60 minutes from it's scheduled administration time or if administration exceeds the time in relation to meals." an "Omission error- Center staff fail to administer an ordered dose to the patient, unless refused by the patient or not administered because of recognized contraindication".	F 693		

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F 693	Continued From page 3	F 693		

During an interview with the Unit Manager (UM) on 10/26/20 at 11:50 AM, s/he stated " It was brought to my attention that a specific nurse was doubling up feedings. I told [the Director of Nursing] and nothing happened with it".

On 11/4/2020 at 1:20 PM, during an interview with the LPN, s/he stated "there is one resident with a Peg-Tube every 4 hours he gets one container [of Jevity] via Peg-Tube". The LPN stated that when administering medications or feedings s/he "pours or prepares the dose, signs the MAR, then gives it to the Resident". S/he also stated that if there was a medication error the procedure is "you would tell the Supervisor or manager, there is a form to fill out, let the doctor know, and let the family know".

During an interview with the Administrator and the Director of Nursing (DON) on 11/4/2020 at 4:40 PM, the DON confirmed that "the issue with the administration of the tube feed was briefly mentioned to her/him" and that s/he "asked the Unit Manager to follow up on it. It may have been missed". The Administrator also confirmed that a missed or untimely dose would be considered a medication error and that the expectation would be to notify the physician. There is no evidence in Resident #1's medical record that the doctor or family were notified of any discrepancies in the administration of the scheduled feedings.