



**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

October 4, 2022

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 investigation survey conducted on **August 26, 2022**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

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

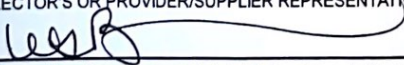
Pamela M. Cota, RN  
Licensing Chief

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

PRINTED: 09/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475027</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/26/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>BENNINGTON HEALTH &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2 BLACKBERRY LANE</b> <b>BENNINGTON, VT 05201</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 580 SS=D	<p>An unannounced on site complaint investigation was conducted by the Division of Licensing and Protection between 8/11 - 8/26/2022. There were regulatory findings as a result of this investigation.</p> <p>Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)</p> <p>§483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment</p>	F 580	<p>F580 Notify of Changes</p> <p>Family was notified of change in wound status.</p> <p>All residents who develop wounds or have wounds that have a change in condition have the potential to be affected by this alleged deficient practice.</p> <p>Nursing staff have been educated on the need to promptly notify the resident representative when there is a wound change in condition.</p> <p>Audits of prompt notification will occur weekly x 4 then monthly x 3. Results will be reported to QAPI committee for 4 months.</p> <p>Responsible: Nursing</p> <p>Date of correction: September 29, 2022</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

CEO

(X6) DATE

9.29.22

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 09/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475027</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/26/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>BENNINGTON HEALTH &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2 BLACKBERRY LANE</b> <b>BENNINGTON, VT 05201</b>	
(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 580	<p>Continued From page 1</p> <p>as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to inform the resident's Power of Attorney (POA) of a change in condition related to the development of a pressure ulcer for 1 of 6 residents in the applicable sample (Resident #3). Findings include:</p> <p>Per record review Resident #3 has a history of a stage 1 pressure ulcer of the right outer ankle that was resolved on 6/10/2022. A skin check documented on 8/9/2022 states "(R) [right] Ankle Deep Red 1.25 cm circular, no [not] open." A skin check documented on 8/12/2022 states "(R) Ankle now stage 2 superficially open. RN will obtain Rx [prescription] order." A nurse's progress note written on 8/16/2022 at 14:39 states "(R) [Right] ankle wound base today with visible screw appears to be working its way out</p>	F 580		

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

PRINTED: 09/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475027</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>08/26/2022</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>BENNINGTON HEALTH &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2 BLACKBERRY LANE BENNINGTON, VT 05201</b>
--	--

(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 580	<p>Continued From page 2 as causative factor in rapid progression/reopening of previously healed PU [pressure ulcer]. FNP [family nurse practitioner] notified of same. Resident remains on Palliation/comfort care with "No antibiotics" as part of [her/his] Advanced Directives. Tx [treatment] applied by staff nurse as ordered by FNP yesterday." There was no evidence in the medical record that the resident's POA was notified of the change in condition related to the development of the right ankle wound.</p> <p>Per interview with a staff registered nurse (RN) on 8/19/2022 at 4:30 PM, when the dressing to the right ankle was removed on 8/16/2022 a large open wound with a piece of "hardware" [surgical screw] protruding from it was revealed. The FNP was notified of the wound however, as of 8/19/2022 the resident's POA had not been notified.</p> <p>Per phone interview with Resident # 3's POA on 8/26/2022 at 3:17 PM, a nurse from the facility had contacted her/him on either 8/23/2022 or 8/24/2022 to provide an update regarding an increase in the dose of Morphine being administered due to increased pain. This is when s/he first learned that the right ankle wound had reopened with an exposed surgical screw. The POA confirmed that s/he had not been notified of the wound when it had been identified on 8/9/2022, or as it progressed on 8/12/2022 and 8/16/2022 until the call 14 or 15 days after the initial discovery, regarding the increase dose of Morphine.</p>	F 580	<p>Tag F580 accepted on 10/4/2022 by S. Freeman/P.Cota</p>	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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

PRINTED: 09/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/26/2022
--	--	--	---

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 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 689	<p>Continued From page 3</p> <p>§483.25(d) Accidents. The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§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 observations, interview, and record review the facility failed to ensure that two of six residents in the applicable sample (Residents #1 and #2) received adequate supervision to prevent accidents, injury, and/or potential abuse. Findings include:</p> <p>1. Per record review Resident #1 has diagnoses that include major depressive disorder, and Alzheimer's Disease. S/he has a history of exhibiting verbal and sexual behaviors toward staff and other residents. A Social Service Note written on 5/8/2022 reflects a care plan focus of "behavior problem due to acute delirium as evidenced by agitation, combativeness, wandering, yelling, refusing food, fluid, medications, **Calling all [women/men] [s/he] sees [significant other's name] and asking them to inappropriately touch [her/him]."</p> <p>On 7/22/2022 at approximately 7:30 PM another resident was found leaning over Resident #1 with their hands under a lap blanket. A statement written by a Licensed Practical Nurse who was on duty states "[Her/His] hand appeared to be near [Resident #1's] groin region... [Resident #1] was yelling out as this contact was happening but in a more amplified way than any of [her/his]</p>	F 689	<p>F689 Supervision</p> <p>Resident # 1 and #2 care plan interventions have been updated.</p> <p>All residents who require direct supervision in an attempt to prevent accidents, injury, and or abuse have the potential to be affected by this alleged deficient practice.</p> <p>Facility will continue to provide adequate supervision to residents who require it. Nursing staff have been educated on care plan interventions and updates for residents requiring direct supervision.</p> <p>Audits of care plans for residents requiring direct supervision for accuracy of interventions will occur weekly x 4 then monthly x 3. Results will be reported to the QAPI committee for 4 months.</p> <p>Responsible: Nursing</p> <p>Date of correction: September 29, 2022.</p>	
-------	--	-------	--	--

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

PRINTED: 09/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475027</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>08/26/2022</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>BENNINGTON HEALTH &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2 BLACKBERRY LANE BENNINGTON, VT 05201</b>
--	--

(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 689	<p>Continued From page 4</p> <p>other behaviors that night." When the residents were separated, Resident #1 began to remove her/his brief and was noted to have been incontinent of bowel. The other resident was later found to have feces on her/his hand.</p> <p>On 7/25/2022, three days after the incident, a care plan intervention was added to "Attempt to keep [resident] away from [Female/Male] Dementia Residents who don't know not to respond to [her/his] inappropriate invitations to touch [her/him]." An intervention added to the care plan on 7/26/2022 states "Dr in and ordered increase in Seroquel due to unrelenting behaviors of screaming, crying for [SO] and [her/his] parents and calling out (often times calling to [female/male] residents to come to [her/him] with sexually explicit requests for them to do to [her/him])." and "Medication Changes to decrease inappropriate sexual invitations." However, there were no interventions in the resident's care plan regarding the need for supervision related to aggressive behaviors or the risk for potential inappropriate touching or sexual abuse.</p> <p>During interview with a Registered Nurse (RN) on the 3 South Unit on 8/17/2022 at approximately 2:30 PM, s/he confirmed that there had not been a specific plan to ensure Resident #1 was safe from undesired sexual contact due to her/his known behaviors. The RN stated that staff "try their best to supervise the residents," but it is "impossible to supervise them all the time and do medication pass and help the LNAs when they need it."</p> <p>During phone interview on 8/11/2022 at 4:06 PM</p>	F 689		
-------	--	-------	--	--

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

PRINTED: 09/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475027</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>08/26/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>BENNINGTON HEALTH &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2 BLACKBERRY LANE BENNINGTON, VT 05201</b>	
(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 689	<p>Continued From page 5</p> <p>with the Director of Nursing (DNS) at the time of the incident, Resident #1 has a history of thinking others are her/his significant other and requesting that they touch her/him and do things to her/him that are sexual in nature. S/he stated that s/he believed that Resident #1 asked the other resident to touch her/him, and the other resident did. The previous DNS confirmed that the resident had a long history of behaviors however, there had been no specific plan in place to prevent negative outcomes resulting from them.</p> <p>2. Per record review Resident #2 has diagnoses that include repeated falls, unsteadiness on feet, difficulty walking, anxiety, dementia, psychosis, cognitive communication deficit, and tremor. Review of nurse progress notes revealed that the resident has had 41 documented falls between 1/1/2022 - 8/17/2022. 35 of the documented falls were unwitnessed with the 6 others documented as witnessed by staff. Per progress notes the resident suffered minor injuries from falls on 1/1, 3/7, 3/8, 5/1, 6/9 (head injury with visit to emergency room for scan), 6/20, and 8/17. A care plan focus initiated on 2/7/2021 states "[Resident] has a potential for falls related to: Agitation, Cognitive Impairment, and HTN (hypertension)." Care plan interventions implemented on 2/24/2022 that state "Staff should intervene and accompany [resident] as soon as they note [her/him] attempting to walk unassisted" were changed on 4/5/2022 to "Line of Sight supervision" and "not allowed to enter rooms unaccompanied because [s/he] is unsafe in [her/his] judgement as to where and when to sit." The Activities of daily living care plan does not address the resident's ambulation status or</p>	F 689		

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

PRINTED: 09/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475027</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/26/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>BENNINGTON HEALTH &amp; REHAB</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2 BLACKBERRY LANE BENNINGTON, VT 05201</b>		
(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 689	<p>Continued From page 6 level of assistance needed for ambulation.</p> <p>During unit observations on 8/11/2022 at 11:00 AM, Resident #2 was observed on the floor in her/his room. The Licensed Practical Nurse (LPN) on duty confirmed that the resident had just had an unwitnessed fall and they were getting her/him up off the floor. Per review of progress notes from 8/11/2022 there was no documentation that the resident had a fall or that s/he had been assessed for injury. On 8/17/2022 Resident #2 sustained two unwitnessed falls and was sent to the emergency room for evaluation.</p> <p>On 8/17/2022 at 2:30 PM during interview a Licensed Nurse Assistant (LNA) who works on 3 North stated that Resident #2 needs 1:1 supervision to prevent falls, but the facility does not provide that kind of care. S/he stated that even though it's "kind of the dementia unit we don't have the ability to provide true dementia care."</p> <p>Per interview with a LNA on 8/17/2022 at approximately 4:30 PM Resident #2 has multiple unwitnessed falls especially on the evening shift. There is not enough staff to provide the kind of supervision or assistance that s/he needs.</p> <p>On 8/19/2022 at 11:27 AM during a phone interview with a Registered Nurse (RN) who is frequently assigned to Resident #2 s/he stated "we don't have the staff to take care of [her/him] [s/he] should be 1-1 but never is. We just don't have the staff to do the basics." The RN also stated "The resident was sent out the day before. S/he has a UTI [urinary tract infection] and dozens of undocumented and unreported falls,</p>	F 689		



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

PRINTED: 09/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475027</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/26/2022</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>BENNINGTON HEALTH &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2 BLACKBERRY LANE</b> <b>BENNINGTON, VT 05201</b>
--	--

(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 689	Continued From page 7 especially on evening shift." When asked if there is any specific expectation for supervision, the RN stated "S/he is care planned to fall, low bed with mats to prevent injury from fall. The RN confirmed that the resident is care planned for "line of site supervision" for safety however, most of the falls sustained by the resident are unwitnessed.	F 689	Tag F689 accepted on 10/4/2022 by S.Freeman/P.Cota	
F 725 SS=F	<p>Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)</p> <p>§483.35(a) Sufficient Staff. 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).</p> <p>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p>	F 725		

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

PRINTED: 09/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475027</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/26/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>BENNINGTON HEALTH &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2 BLACKBERRY LANE BENNINGTON, VT 05201</b>	
(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 725	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to ensure sufficient staff to provide nursing and related services to assure all resident care and safety needs were met.</p> <p>1. During observations of the 2nd floor on 8/11/2022 at 12:45 PM the Registered Nurse (RN) on duty reported that each day there is one RN or Licensed Practical Nurse (LPN) and one Licensed Nurse Assistant (LNA) assigned to the unit each shift. According to the RN s/he is responsible to assist the LNA with resident care needs and transfers with mechanical lifts which require 2 staff assistance in addition to nursing duties such as medication pass and treatments. The RN stated, "there is going to be three new admissions today and one is on Hospice." The RN also stated that when s/he or the LNA go to lunch it only leaves one person on the floor.</p> <p>Per interview on 8/11/2022 at 2:15 PM with the LNA assigned to the 2nd floor there are now 15 residents who reside on the unit. Two new admissions arrived today, and a Hospice patient is also being admitted today. The LNA stated "I am told that the residents on this unit don't need a lot of help. Even the residents who don't need help with their care still have needs." Per the LNA there are 4 residents on the unit that require the use of a 2 person Hoyer lift at least twice during the shift and s/he has to ask the nurse to help her/him each time. This takes the nurse away from their duties like medication pass and treatments. "I have residents who need to be turned, and changed, a lot of them don't like to undress at night so I have to undress them, clean</p>	F 725	<p>F725 Sufficient Staffing</p> <p>Resident # 1 and #2 care plan interventions have been updated.</p> <p>Facility has hired a staffing coordinator. Jobs have been posted internally and with agency.</p> <p>Facility will continue to staff at the state minimum and will provide direct supervision when necessary.</p> <p>Staff have been educated on attendance policies and to utilize ancillary staff when feeling overwhelmed and need assistance with tasks.</p> <p>Audits of staffing sheets and residents requiring direct supervision will occur weekly x 4 then monthly x 3. Results will be reported to QAPI committee for 4 months.</p> <p>Responsible: Nursing</p> <p>Date of Correction: September 29, 2022.</p>	

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

PRINTED: 09/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475027</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/26/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>BENNINGTON HEALTH &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2 BLACKBERRY LANE</b> <b>BENNINGTON, VT 05201</b>	
(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 725	<p>Continued From page 9</p> <p>them, and dress them back up. It's just too much for one person." When we take our lunches, it only leaves one person on the whole floor, and it's not safe." When asked if there are care needs that don't get met, the LNA stated "sometimes."</p> <p>Review of the facility Daily Attendance Report for July and August 2022 confirmed that the 2nd floor is consistently staffed with one RN or LPN and one LNA on all three shifts.</p> <p>Per interview with the Director of Nursing (DNS) on 8/11/2022 at 6:15 PM the residents on the 2nd floor do not require a lot of care. The facility has not been admitting residents to the 2nd floor South Unit because of staffing. However, the new Hospice admission was being admitting to the South Unit. The DNS confirmed that there is only one nurse and one aide scheduled on the 2nd floor.</p> <p>2. On 8/11/2022 at 4:45 PM per interview with a contract Licensed Practical Nurse scheduled on the 3rd floor South Unit on there are two LNAs and her/himself scheduled on the unit which is per normal. S/he stated that there is not enough staff to do everything and keep the residents safe. "There are so many behaviors on the evening shift and there is nobody here to help."</p> <p>Per review of the Resident Census and Conditions of Residents report dated 8/11/2022 there are 25 residents with documented psychiatric diagnosis (excluding dementia and depression), 19 residents with dementia or Alzheimer's Disease, 8 residents with behavior healthcare needs.</p>	F 725		

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

PRINTED: 09/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475027</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/26/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>BENNINGTON HEALTH &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2 BLACKBERRY LANE</b> <b>BENNINGTON, VT 05201</b>		
(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 725	<p>Continued From page 10</p> <p>3. During observations throughout the on-site investigation the Activities Calendar was noted on the unit. Per review the last activity provided on each day throughout the month is at 3:30-4:00 PM. Per interview with the facility Executive Director on 8/17/2022 at there is an open position for evening activities that has not been filled. She confirmed that there were currently no activities offered after 4:00PM.</p> <p>4. Per record review Resident #2 has diagnoses that include repeated falls, unsteadiness on feet, difficulty walking, anxiety, dementia, psychosis, cognitive communication deficit, and tremor. Review of nurse progress notes revealed that the resident has had 41 documented falls between 1/1/2022 - 8/17/2022. 35 of the documented falls were unwitnessed with the 6 others as witnessed by staff. A falls care plan intervention reflects that the resident should be in "Line of site supervision."</p> <p>Per interview with several staff members there is not enough staff to provide adequate supervision to this resident. It is not possible for them to supervise the resident all the time, especially on evening shift when there are only four LNAs and two nurses between 3rd floor North and South Units. Per interview with a LNA on 8/17/2022 at approximately 4:30 PM there is not enough staff to provide the kind of supervision or assistance that s/he needs. Resident #2 has multiple unwitnessed falls especially on the evening shifts.</p> <p>Refer also to F689.</p>	F 725	<p>Tag F725 accepted on 10/4/2022 by S. Freeman/P.Cota</p>		