Division of Licensing and Protection HC 2 South, 280 State Drive Waterbury, VT 05671-2060 <u>http://www.dail.vermont.gov</u> 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

November 23, 2022

Ms. Amy Russell, Administrator Bennington Health & Rehab 2 Blackberry Lane Bennington, VT 05201-2300

Dear Ms. Russell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on October 14, 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,

Jamela M Cota RN

Pamela M. Cota, RN Licensing Chief

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** PROVIDER'S PLAN OF CORRECTION (EACH 0(5) COMPLE SUMMARY STATEMENT OF DEFICIENCIES 1D CORRECTIVE ACTION SHOULD BE (X4) ID TION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG 11/23/22 E 000 Please note that the filing of the plan E 000 Initial Comments of correction does not constitute admission to any of the alleged The Division of Licensing and Protection violations set forth in this statement of conducted an annual emergency preparedness deficiencies. This plan of correction is survey on 10/13/2022. The facility was found to be in substantial compliance with emergency being filed as evidence of the facility's preparedness regulations. continued compliance will all F 000 applicable laws. F 000 INITIAL COMMENTS An unannounced onsite annual rectification survey was conducted in conjunction with six complaint investigations on 10/9/2022 -10/14/2022. On 10/11/2022, the survey team identified and notified the facility of deficiencies at the Immediate Jeopardy (IJ) level at F726 and F880, related to violations around staff training and infection prevention and control. The IJ was found to be removed on 10/12/2022, prior to the conclusion of the survey. Due to a pattern of harm identified at F686 and F692, substandard quality of care was also identified. The facility is licensed for 91 beds and had a census of 54 at F 550 the time of the survey. The regulatory violations Resident #33, LNA who provided care to identified under 42 CFR Part 483 include: Resident #33 was re- educated on F 550 Resident Rights/Exercise of Rights Residents Rights to include F 550 CFR(s): 483.10(a)(1)(2)(b)(1)(2) dignity/privacy with care. SS=D §483.10(a) Resident Rights. All Residents have the potential to be The resident has a right to a dignified existence, self-determination, and communication with and affected by this deficient practice. access to persons and services inside and outside the facility, including those specified in Nursing staff will be reeducated on Residents rights to include dignity/ this section. privacy with care. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's (X6) DATE LABORATORY DIREGURS OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE 22 LU MP Þ Er Min Any deficiency statement ending with an asterisk (*) denotes a deficiency which the inditution 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.

	MENT OF HEALTH AN	D HUMAN SERVICES				FORM	: 10/31/2022 APPROVED
CENTER	S FOR MEDICARE & N	MEDICAID SERVICES					0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION (X	(3) DATE S COMPL	ETED
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NAME OF PI	ROVIDER OR SUPPLIER			2 1	BLACKBERRY LANE		
BENNING	TON HEALTH & REHAB			B	ENNINGTON, VT 05201		
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F 550	individuality. The facil promote the rights of §483.10(a)(2) The facil access to quality care severity of condition, must establish and m practices regarding th provision of services residents regardless §483.10(b) Exercise The resident has the rights as a resident of or resident of the Uni §483.10(b)(1) The facility. §483.10(b)(2) The facility. §483.10(b)(2) The facility. §483.10(b)(2) The reference, coercio from the facility. §483.10(b)(2) The reference, or reprisal from the facility. §483.10(b)(2) The reference, or free of interference, or reprisal from the facility. Based on observation determined that the care was provided to manner for 1 resider standard survey sam Observation on 10/9	ity must protect and the resident. cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ransfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her f the facility and as a citizen ted States. cility must ensure that the a his or her rights without n, discrimination, or reprisal esident has the right to be coercion, discrimination, and lity in exercising his or her orted by the facility in the trights as required under this T is not met as evidenced on and interview it was facility failed to ensure that or residents in a dignified it (Resident #33) in a hople of 35. Findings include: /22 at 9:00 PM revealed a sistant (LNA) who entered	F	550	Care observation audits will be conducted to ensure staff are maintaining dignity/privacy practices with care. Audits will conducted weekly X3 then mon X3 by the Director of Nursing of designee. The results of the audits will be reported and reviewed at the Q/ committee meeting X4 months evaluated as needed. Oversight be provided by the DON or des F550 Pot accepted 11/122 stre	or or API and will ignee.	
	room #204. The sta window bed where it	ff member proceeded to the was noted the privacy					
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FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 10/31/2022 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A-BUILDING AND PLAN OF CORRECTION С 10/14/2022 475027 B_WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON HEALTH & REHAB** BENNINGTON, VT 05201 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID. COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 550 F 550 Continued From page 2 curtain was pulled to approximately 3/4 of the way down towards the foot of the bed. The staff member went behind the partially pulled curtain where the residents bare/naked thighs and a yellow brief was visible on the resident from the doorway of room #204. The staff member was observed pulling the back of the yellow brief down revealing the residents buttocks, and providing incontinence care to Resident #33. Interview on 10/9/22 at 9:10 PM with the LNA revealed she/he was an LNA who was working as emergency relief staff. The LNA stated this was her/his 3rd shift in this facility. The LNA confirmed that she/he was providing peri care to Resident #33 and she/he confirmed that the privacy curtain was not pulled over far enough to ensure privacy for the resident to ensure and maintain his/her dignity. F 584 F 584 Safe/Clean/Comfortable/Homelike Environment F 584 Laundry Carts and area under the CFR(s): 483 10(i)(1)-(7) SS=E wooden pallet have been cleaned and disinfected. §483.10(i) Safe Environment. The resident has a right to a safe, clean, 3rd floor clean utility room has been comfortable and homelike environment, including cleaned & organized. The door has lock but not limited to receiving treatment and has been replaced and a lock added to supports for daily living safely. the medication cabinet. The sign has been updated to include The facility must provide-§483.10(i)(1) A safe, clean, comfortable, and medication. homelike environment, allowing the resident to Resident #45's bed is being made daily use his or her personal belongings to the extent after care is provided. possible. (i) This includes ensuring that the resident can 2nd Floor hallways have been cleaned receive care and services safely and that the of debris. physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for 2nd Floor dining area and

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Event ID: JB5X11

Facility ID: 475027

If continuation sheet Page 3 of 125

475027 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BENNINGTON HEALTH & REHAB 2 BLACKBERRY LANE BENNINGTON, VT 05201 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 CORRECTIVE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
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 F 584 Continued From page 3 the protection of the resident's property from loss or theft. \$483.10(1)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comtrable interior; \$483.10(1)(3) Clean bed and bath linens that are in good condition; \$483.10(1)(4) Private closet space in each resident room, as specified in \$483.90 (e)(2)(iv); \$483.10(1)(5) Adequate and comfortable lighting levels in all areas; \$483.10(1)(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(1)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by; Based on observations and interviews, the facility failed to provide residents with a safe, clean, comfortable, and homelike environment, as evidenced by poor performance of Housekeeping, Maintenance, Infection Control and Nursing Services necessary to maintain a sanitary and orderly facility. Findings include: 1. Observation on 10/11/22 at 01:27 PM of the laundry department, contained laundry carts, for the transport of soiled linens. One cart was noted to be unclean with various items of built-up debris such as used loves, food particles, papeer 	

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Event ID: JB5X11

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F 584	Continued From page products, a hair tie, a unrecognizable partic lint, dust and debris u contains large bucke chemicals. Interview with a laundry attend appearance of the dii build up under the wo Another observation and interview with the Preventionist (ICP) w afternoon on 10/11/2 confirmed that the la wood pallet near the filthy. The ICP confir soiled areas and disi been done and shou prevent the spread of 2. On 10/11/22 at 08 floor unit, revealed a station which is labe code pad. This same such on the facility n Licensed Nurse Ass code was. This LNA stated. "it's the same	e 4 meal ticket, and other cles. There were layers of under a wooden pallet that ts of washing machine at the time of observation ant, confirmed the rty laundry cart and dirt/grime boden pallet. of the laundry department e Infection Control was conducted the same t2 at 4:15PM. The ICP undry cart and under the washing machines were med that cleaning visible nfecting linen carts had not ld be to deter pests and of communicable diseases. :45AM observation of the 3rd door across from nurse led "clean utility" with a key e room is also labeled as hap. This surveyor asked a istant (LNA) what the door knew the door code and e for all other utility rooms"	F 584	care related to bed making. Housekeeping and Dietary sta educated on routine cleaning r common areas and kitchenette Dietary staff has been provided food storage and refrigerator/f cleaning. Environmental Services has be on approved pest control device Social Services and Recreatio educated on home-like enviror resident room personalization. Observation audits will be con weekly X3 then monthly X3 following: Laundry carts and room clean Utility/Med room cleaning, F beds are made, Dining area, refrigerator/freezer cleanlines Food storage Hallway cleanliness, Pest Control, Resident Room personalization. The results of the audits will and reviewed at the OAPI Con	elated to s. d education of reezer een educated ees. n has been nment and nducted on the ing. Clean tesident room is	
	and proceeded to le entrance, the small medication storage	t two surveyors in Upon room appeared to be a area rather than a "Clean		meeting X4 months and evalu- needed. Oversight will be pro- the Administrator or designed	ovided by	
	medications in a cat medications on the with needles (box of cabinet, and other s filthy with debris on sized area of sticky	ained over the counter binet, a blue plastic tote full of floor, Lab supplies, syringes 26G x1/2" syringe) in a upplies. The utility room was the floor and a dark quarter substance. The LNA oor was dirty, and that s/he		F584 Poc accepted 11/1/22	SFREEmanRd	

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES			OMB N	0.0938-039
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F 584	Continued From page	e 5	F 584			
	did not "ever really no	eed anything in here".				
	Observation and inte	rview on 10/11/22 at 2:17PM				
	with a housekeeper	confirmed that the floor was				
	dirty and s/he "does	usually wash the 'clean				1
	Utility' floor but has b	een out for two weeks". This				
	housekeeper reveale	ed that all of 3rd floor is				
	her/his cleaning resp	oonsibility. S/he stated that a nurse observe while she				
	s/he had never had a	is room and was not aware				
	that s/be should not	enter due to it containing				
	medications, but did	know the code.		14 - C		
	Observation of the 3	rd floor "Clean Utility" room				
	and Interview on 10/	11/22 at 4:45PM with the ICP				
	confirmed that the flo	oor was dirty and that the				
	room was clearly lab	eled "Clean Utility" outside				
	the door and on the	facility map but was being				
	used as a "medication	on room" which did not				
	contain such items a	as one would expect to have				
	in a clean utility roor	n. The ICP confirmed that een cleaned in a while and				
	that only nurses sho	ald have access.				
	ulat only nuises sho					
	A day later, on the a	fternoon of 10/12/22 at				
	2.30PM. Observatio	in and interview with a				,
	Genesis Nurse Con	sultant confirmed the room				
	was not being used	as a "Clean Utility" and the				
	floor was still dirty.					
		ALLAND -+ 2.10DM of the 3rd				
	3. Observation on 1	0/10/22 at 3:10PM of the 3rd				
	floor South unit, roo	m 314 revealed two stripped resident #45 lying on the bed				
	unmade beds, with	w. This resident has dementia				
	and chose the wron	g bed to rest on. S/he does				
	not have a room- m	ate. Both beds have pressure				
	reducing mattresse	s and are not protected from				
	being soiled. Intervi	ew at this time with a				
	· · · · · · · · · · · · · · · · · · ·	Nurse (LPN) who is familiar				

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION С 10/14/2022 R. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON HEALTH & REHAB BENNINGTON, VT 05201 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID. (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG F 584 Continued From page 6 F 584 with this resident, stated "We leave the beds unmade in room 314, because the resident is a heavy wetter and goes through all linens constantly, so we make his bed at 7:30PM". Interview with a travel nurse on 10/10/22 at 3:25PM confirmed that there were no sheets on the beds in room 314. Observation on 10/11/22 at 10:30AM revealed both beds were unmade throughout the day. Observation on 10/12/22 at 09:00AM, resident's bed was made and at 1:25PM it was not made. Interview with the Regional Nurse Consultant confirmed that both beds in room 314 were without linens and both beds should be made every day. 4. Observation on 10/9/22 at 8:40 PM of the second floor, revealed a lot of debris in the hallway where resident rooms are located. Interview on 10/9/22 at 8:50 PM with the emergency relief Licensed Practical Nurse (LPN), who confirmed the hallway where resident rooms are located was littered with debris consisting of gloves, pieces of blue plastic that were pieces of the disposable gowns, clear plastic wrappers that are the packaging to protective eyewear, small pieces of paper and dirt. She/he stated that staff have not had time to clean on the unit and to her/his knowledge there are no housekeeping staff at that time available. 5. Observation on 10/9/22 at 9:41 PM of the second floor dining area revealed the following issues in the resident dining area and kitchenette: *tray with dirty dishes and exposed food; *dirty refrigerator and freezer with spills inside on the shelves and on the inside of the door shelves; If continuation sheet Page 7 of 125 Facility ID: 475027 Event ID: J85X11

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION С 10/14/2022 8. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON, VT 05201 BENNINGTON HEALTH & REHAB** (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 584 Continued From page 7 F 584 *11 pieces of cheese partially wrapped in plastic wrapped, that are curled and dried on one corner of each piece; *cabinet drawers with miscellaneous kitchen disposables (small paper bags, pieces of various sizes of tinfoil, packets of tea, hot cocoa and a binder clip) scattered through the drawer and what appeared to be coffee grounds mixed in with these items; *Another drawer with small plastic disposable lids, some in the plastic protective sleeve and many out of the sleeve and scattered throughout the drawer, an individual package of crackers, and various single serve condiment packets, and what appeared to be coffee grounds mixed in with these items; *dirty microwave; *large metal mouse trap noted under the a utility rack in the kitchenette serving area; *a rat trap located between the refrigerator and the wall of the kitchenette serving area. Observation on 10/10/22 at 8:15 AM revealed the above noted issues identified on 10/9/22 at 9:41 PM were still present. Interview on 10/10/22 at 8:45 AM with the Food Service Director Supervisor, who confirmed the above findings. She/he revealed that some parts of the kitchenettes and serving areas are the responsibility of housekeeping and some by nursing 6. Observation on 10/10/22 at 9:00 AM revealed resident rooms #201, #205B, #207A, #210, #211B, and #212B were not personalized to the resident, no pictures on the walls, or other items that revealed resident self-expression. Room #204 was very cluttered with clothes that were

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Event ID: J85X11

Facility ID: 475027

If continuation sheet Page 8 of 125

PRINTED: 10/31/2022

		MEDICAID SERVICES	(X2) MULTIPLE CO	NSTRUCTION	OMB NO. 0	RVEY
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F 584	Continued From pag draped over furniture surfaces.	ge 8 e, window sills, and other flat	F 584		6	
F 585 SS=E	who was an emerge confirmed that there contain personal iter personal care produ- why resident rooms Grievances CFR(s): 483.10(j)(1) §483.10(j) Grievance §483.10(j)(1) The re grievances to the fa- that hears grievance reprisal and without reprisal. Such griev- respect to care and furnished as well as furnished, the beha- residents, and other facility must make p resolve grievances accordance with thi §483.10(j)(2) The re facility must make p resolve grievances accordance with thi §483.10(j)(3) The fi on how to file a grief to the resident. §483.10(j)(4) The fi grievance policy to of all grievances re contained in this pa	es. esident has the right to voice cility or other agency or entity es without discrimination or ances include those with treatment which has been that which has not been vior of staff and of other r concerns regarding their LTC esident has the right to and the prompt efforts by the facility to the resident may have, in	F 585	F585 Allegation of abuse was and reported to the state a All Residents have the pot affected by this deficient p Grievances have been revi investigated. Summary of and any corrective action been documented as the re- confirmed or not confirm. Staff will be educated on to policy. Weekly audits of grieva concerns and responses conducted by the Admir designee weekly X3 the X3.	agency. ential to be practice. iewed, f findings taken has esults of a ed grievance. the grievance mces/ will be iistrator or	1

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DEPARTA	MENT OF HEALTH AN	MEDICAID SERVICES				0938-039
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		475027		TREET ADDRESS, CITY, STATE, ZIP CODE		
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	CUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF		(X5) COMPLETION
(X4) ID PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	PROPRIATE	DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		DEFICIENCY)		
				The results of the audits w	ill be re-	
F 585	Continued From page	e 9	F 585	ported and reviewed in the	; QAPI	
		rievance policy must	1	committee meeting and ev	aluated as	
	include:		- 8	indicated. Oversight will	be provided	
	(i) Notifying resident	individually or through		by the Administrator,		
	postings in prominen	t locations throughout the file grievances orally		F585 POL accepted 11/7	22 SFreema	n Ros pm
	(meaning spoken) of	in writing; the right to file		FSOS POL acception "1"		
	orievances anonymo	usly; the contact information				
	of the grievance offic	cial with whom a grievance				
	can be filed, that is, I	his or her name, business				
	address (mailing and	t email) and business phone le expected time frame for				
	number, a reasonab	w of the grievance; the right				
	to obtain a written de	ecision regarding his or her				
	grievance; and the c	ontact information of				
	independent entities	with whom grievances may				
	be filed, that is, the p	pertinent State agency, t Organization, State Survey	1			
	Quality Improvemen	ong-Term Care Ombudsman				1
	program or protectio	n and advocacy system;				
	(ii) Identifying a Grie	vance Official who is	1			
	responsible for overs	seeing the grievance process,				
	receiving and tracking	ng grievances through to their				
	conclusions; leading	any necessary investigations aining the confidentiality of all				
	information associal	ted with grievances, for				
	example the identity	y of the resident for those				
	orievances submitte	d anonymously, issuing				
	written grievance de	ecisions to the resident; and				
	coordinating with sta	ate and federal agencies as f specific allegations;				
	(iii) As necessary ta	aking immediate action to				1
	prevent further pote	ntial violations of any resident				
	right while the allege	ed violation is being		1		
	investigated;	EXER 12(a)(1) immediately				
	(iv) Consistent with	§483.12(c)(1), immediately violations involving neglect,				
	abuse including init	uries of unknown source,				
	and/or misappropria	ation of resident property, by				1
	1100 Barriel 1100		1			

EPARTN	MENT OF HEALTH	AND HUMAN SERVICES				RM APPROVE 10: 0938-03
TEMENT	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON			TE SURVEY
		475027	8. WING		1	C 0/14/2022
	ROVIDER OR SUPPLIER		STREE	T ADDRESS, CITY, STATE, ZIP CODE		
AME OF Pr	ROVIDER OR BOTT EICH			CKBERRY LANE		
ENNING	TON HEALTH & REH	AB	BEN	NINGTON, VT 05201		
(X4) ID PREFIX TAG	JEACH DEELCH	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	UED BE	(X5) COMPLETIO DATE
F 505	Captioned From F	2000 10	F 585			
F 585	Continued From p			1 4		
	anyone turnishing	services on behalf of the Iministrator of the provider; and				
	as required by Sta	ate law				1
	(v) Ensuring that	all written grievance decisions				
	include the date the	he grievance was received, a				
	summary stateme	ent of the resident's grievance,				
	the steps taken to	investigate the grievance, a				
	summary of the p	ertinent findings or conclusions				
	renarding the resi	ident's concerns(s), a statement				
	as to whether the	grievance was confirmed or not				
	confirmed, any co	prrective action taken or to be				
	taken by the facili	ity as a result of the grievance, written decision was Issued;	× 1			
	and the date the	priate corrective action in				
	(VI) Taking appro	State law if the alleged violation				
	of the residents' r	ights is confirmed by the facility				
	or if an outside et	ntity having jurisdiction, such as				
12	the State Survey	Agency, Quality Improvement				
	Organization, or	ocal law enforcement agency				
	confirms a violati	on for any of these residents'				
	rights within its a	rea of responsibility; and				
	(vii) Maintaining	evidence demonstrating the				
	result of all grieva	ances for a period of no less than issuance of the grievance				
	decision.	issuance of the grievance				
	This REOUREM	ENT is not met as evidenced				
	by:					
	Based on observ	vations, interviews and record				
	review the facility	/ failed to ensure that all written				
	grievance decision	ons include the date the	1			
	grievance was re	eceived, a summary statement of				
	the resident's gri	evance, the steps taken to				
	investigate the g	rievance, a summary of the s or conclusions regarding the				
	pertinent findings	rns(s), a statement as to whether				
	the meyance we	as confirmed or not confirmed,				10
	any corrective a	ction taken or to be taken by the				
	facility as a result	It of the grievance, and the date				
		ion was issued. Findings include:				

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

Event ID: JB5X11

Facility ID: 475027

If continuation

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PRINTED: 10/31/2022 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 585 Continued From page 11 F 585 On 10/14/22 at 1 PM during a review of the facility grievance book it was noted that there were numerous names (2 in January 2022, 2 in April 2022, 3 in July 2022, 2 in September 2022) indicating a grievance had been filed by the named individuals without evidence of investigation or a summary of findings. Among these grievances was one alleging abuse which had not been reported to any State Agency but was investigated as part of the survey. Upon interview with the Administrator, he/she confirmed he/she did not know what happened with the grievances and he/she had no process to monitor these or ensure follow up. F 609 F609 Reporting of Alleged Violations F 609 Allegations of abuse for Resident #11 CFR(s): 483 12(c)(1)(4) SS=D have been investigated and reported to §483.12(c) In response to allegations of abuse, the appropriate state agency. neglect, exploitation, or mistreatment, the facility Grievances have been reviewed to must ensure any allegations of abuse were §483.12(c)(1) Ensure that all alleged violations reported. involving abuse, neglect, exploitation or mistreatment, including injuries of unknown Staff was educated on the Abuse source and misappropriation of resident property, prohibition policy and reporting of are reported immediately, but not later than 2 alleged violations. hours after the allegation is made, if the events that cause the allegation involve abuse or result in Weekly audits will be conducted of serious bodily injury, or not later than 24 hours if allegations to ensure allegations of abuse are reported timely weekly X3 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to then monthly X3 by the the administrator of the facility and to other Administrator or designee. officials (including to the State Survey Agency and The results of the audits will be readult protective services where state law provides ported and reviewed at the QAPI for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

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

Event ID: JB5X11

Facility ID: 475027

If continuation sheet Page 12 of 125

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES	1	CONCEPTION	(X3) DATE	
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		CONSTRUCTION		LETED
		475007	B. WING		1	
		475027		TREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PI	ROVIDER OR SUPPLIER			BLACKBERRY LANE		
BENNING	TON HEALTH & REHAB			ENNINGTON, VT 05201		
	CLIMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION)	RECTION	(X5) COMPLETIC
(X4) ID PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE A DEFICIENCY	PPROPRIATE	DATE
F 609 Continued From pag		t the results of all	F 609	Committee meeting mont evaluated as indicated. O be provided by the Admir designee.	versignt will histrator or	
	designated represent accordance with Sta Survey Agency, with incident, and if the a appropriate correctin This REQUIREMEN by: Based on observati interview the facility alleged violations in exploitation, or mist unknown source an property, are report than 2 hours after th appropriate State A	administrator or his or her tative and to other officials in ite law, including to the State in 5 working days of the lleged violation is verified ve action must be taken. (T is not met as evidenced ion, record review, and staff failed to ensure that all volving abuse, neglect, reatment, including injuries of d misappropriation of resident ed immediately, but not later he allegation is made to the gencies for one resident vo investigated. Findings		F609 POL accepted 11/7	122 SFreeman	put ponc
	note from Social Se information regardination abuse from Resider appeared to be an in the grievance from personal care recein Nursing Assistant) the staff "rubbing m my liking and clean There were no con this had been repoin was confirmed with Licensing and Proti- been reported. At a the facility Adminis	he facility grievance book a rivices dated 9/7/22 containing ing an allegation of sexual int #11 was found. The note nitiation of an investigation of Resident #11 regarding ved from a LNA (Licensed in which he/she complained of ny chest a little too much for ed my crotch a little too good". clusions drawn or indication rted to any State Agencies, it the State Division of ection that this incident had not pproximately 2PM on 10/14/22 trator confirmed the allegation ted to any State Agencies.				

		ND HUMAN SERVICES			OMB NO_	
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE C	CONSTRUCTION (X3) DATE SU COMPLE	JRVEY TED
PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		
						С
		475027	B. WING _			/2022
	OVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	
	CONDERVOIT SOLVENE				3LACKBERRY LANE	
ENNING	TON HEALTH & REHA	В		BE	ENNINGTON, VT 05201	
	CLIMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETIC
(X4) ID PREFIX	JEACH DEFICIEN	VCY MUST BE PRECEDED BY FULL	PREFID		CROSS-REFERENCED TO THE APPROPRIATE	DATE
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	
			-			
		10	Fé	641	F641	
F 641	Continued From pa			641	Resident #49 MDS was modified to	
F 641	Accuracy of Assess	sments			indicate Bipap use.	
SS=D	CFR(s): 483.20(g)					
	6 (00 00(a) Apouro	ov of Assessments			Resident #204 MDS was modified to	
	§483.20(g) Accura	ust accurately reflect the			include the G-tube in section K0310 pa	rt
	resident's status.	ust accurately reneed the			B G-tube care	
	This PEOLIBEME	NT is not met as evidenced			orders have been obtained and care plan	
	by:				has been developed.	- D
	Based on Observa	ation, interview and record				
	review it was deter	mined that the facility failed to			House audit conducted to ensure	
	complete accurate	assessments for 2 of 37		1	resident's using Bipaps are coded	
	residents in a stand	dard survey sample.	1		accurately on the MDS and Bipap is	
	(Residents #49, an	d 204) Findings include:			working correctly.	
	1. Per record revie	w Resident number #49 was			House audit completed on Residents w	th
	admitted to the fac	ility on 9/17/22 with diagnosis			G-tubes to ensure Residents with G-tub	es
	of Chronic Obstruc	tive Pulmonary Disease with			are coded correctly on the MDS, have	
	(Acute) Lower Res	piratory Infection, Acute and		- 8	orders for g-tube care and have carepla	ns
	Chronic Respirator	ry Failure with Hypoxia, Morbid			in place.	
	(Severe) Obesity v	vith Alveolar Hypoventilation,		1		
	Shortness of Breat	th, and Dependence on			Education has been provided to MDS s	aft
	Supplemental Oxy	gen (Not all inclusive). Review			and those who complete the MDS on th	e
	of the Physician of	ders revealed a signed order AP dated 09/16/22.			accuracy of MDS coding of section O a	nd
	for the use of bi-Pr	AF Ualed 03/10/22.			К.	
	During interview 0	n 10/12/22 at 2:45 PM the				
	During interview o	t s/he is to use a Bi-PAP			Education has been completed with	
	machine /a Bi- PA	P machine is used as a form of			licensed staff related to Bipap use and	
	non-invasive venti	lation (NIV) therapy used to			Enteral tube policies.	
	facilitate breathing) while s/he is napping during				
	the day and at nig	ht when s/he is sleeping. The			Audits of MDS coding of section O pa	rt
	resident stated that	at s/he used this at home and			G section K0310 part B, treatment	
	should be using it	in the nursing facility.			orders for G-tubes and Bipap use will	
		9			be conducted weekly X3 then monthly	
	Interview on 10/12	2/22 at 3PM with the Registered			X3 by MDS or designee.	
	Nurse (RN)/Nurse	Practice Educator (NPE) who				
	stated that "the re-	sident refuses to wear the				
	Bi-PAP, it's not ev discontinued" The	en set up and it should just be				

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		D HUMAN SERVICES			OMB NO	0938-0391
CENTERS	FOR MEDICARE & N	IEDICAID SERVICES		CONSTRUCTION	(X3) DATE 5	SURVEY
STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMPL	EIED
		475027	B. WING		10/1	14/2022
NAME OF DE	OVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	ONDER OR GOT LIER			BLACKBERRY LANE		
BENNINGT	ON HEALTH & REHAB		E	BENNINGTON, VT 05201		
			ID	PROVIDER'S PLAN OF CORR	ECTION	(X5) COMPLETION
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE
F 641	have not been consulting resident's BI-PAF resident's refusal and too hard for her/him t Minimum Data Set (M date (ARD) 9/23/22 i Non-Invasive Mecha (BiPAP/CPAP) is coor prior to this admissio NO", indicating not u Interview on 10/14/2 Licensed Practical N who confirmed the B correctly on the adm The LPN/MDS Coord BI-PAP should have prior to this admissio resident. 2. Per record review admitted to the facili diagnoses Type 2 D Complications, Fron Function Deficit Foll Pressure Ulcer of Sa Dysphagia Orophan assessment dated 9 resident was admitte allows for food, fluid directly to the stoma During interview on Registered Nurse (F	I/or a respiratory therapist Ited to do a re-evaluation of P needs in relation to the I complaints of blowing air o tolerate". IDS) assessment reference in SECTION O part G inical Ventilator Ided "NO" indicating not used in to the facility and is coded" sed while a resident. 2 at 10:47 AM with the urse (LPN) MDS coordinator, i-PAP was not coded ission MDS ARD 9/23/22. dinator confirmed that the been coded as being used in and currently, while a	F 641	The results of the audits v ported and reviewed at the Committee meeting with on needed X4 months. Over provided by the MDS coordesignee. F641 POL accepted 11/7/ba	e QAPI evaluation as sight will be ordinator or	
	resident's G tube " a	nd "nursing doesn't do not used". Record review				
	I anything with it it is	not used". Record review		Eacility ID: 475027		-

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES			PRINTED: 10/ FORM APP OMB NO. 093	ROVED
STATEMENT (S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X?) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVE COMPLETED	
		475027	B. WING		10/14/20	22
	ROVIDER OR SUPPLIER		2 BI	EET ADDRESS, CITY, STATE, ZIP CODE LACKBERRY LANE NNINGTON, VT 05201		
(X4) ID PREFIX TAG	JEACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPRO DEFICIENCY)	3E	(X5) COMPLETION DATE
F 641	site assessment, or The Minimum Data & Reference Date (AR part B coding indical place while not a res- resident in this facilit Interview on 10/13/2 Practical Nurse (LPI confirmed the MDS incorrectly coded ar G-Tube in place and orders in place for th no care being provid Baseline Care Plan CFR(s): 483.21(a)(1) §483.21 Comprehent Planning §483.21(a) Baseline §483.21(a)(1) The fil implement a baseline that includes the inse effective and person that meet professio The baseline care p (i) Be developed wit admission. (ii) Include the minim necessary to prope including, but not lin	RN at this time who are no orders for the G-tube care/treatment. Set (MDS) with Assessment (D) of 1/5/22 Section K 0310 tes there was no G tube in sident or currently as a ty. 22 12:58 PM with the Licensed N) MDS coordinator, who section K 0310-part B is ad the resident in fact has a d there are no treatment ne G- tube and that there is ded for the G-Tube.)-(3) nsive Person-Centered Care e Care Plans acility must develop and he care plan for each resident structions needed to provide n-centered care of the resident nal standards of quality care. Dan must- thin 48 hours of a resident's mum healthcare information rly care for a resident mited to- ed on admission orders. s.	F 641	F655 Resident #52's care plan has updated to reflect current m ADL need, Skin prevention devices, base- line and com needs. Resident #204's care plan updated to reflect current goals and interventions Resident #37 Diet orders of nutrition care plan has been New Admissions will have care plan development with hours of admission.	obility, , assistive prehensive n has been conditions, btained and n developed. base- line hin 48	16 of 125

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Event ID: J85X11

Facility ID: 475027

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING С 10/14/2022 R WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES in. (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG Education will be provided to the F 655 interdisciplinary team on baseline care Continued From page 16 F 655 planning following the Person Centered (E) Social services. (F) PASARR recommendation, if applicable. Care plan policy. §483.21(a)(2) The facility may develop a Audits will be conducted of baseline comprehensive care plan in place of the baseline careplan development within 48 hours care plan if the comprehensive care planof Admission weekly X3 and monthly (i) Is developed within 48 hours of the resident's X3 by the DON or designee admission. (ii) Meets the requirements set forth in paragraph The results of the audits will be re-(b) of this section (excepting paragraph (b)(2)(i) of ported and reviewed at the QAPI this section). Committee meeting with evaluation as needed monthly X4. Oversight will be §483.21(a)(3) The facility must provide the provided by the DON or designee. resident and their representative with a summary of the baseline care plan that includes but is not F655 POL accepted 11/7/22 SFreeman Pul proce limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to develop and implement a baseline care plan for 3 of 37 residents in a standard survey sample. (Resident identifiers #37, 52, and 204) Findings include: 1. Observation of Resident #52 revealed that she/he has a right sided BKA (below the knee amputation), and a right legged prosthetic was noted at her/his bedside. Record review revealed that Resident #52 was admitted to the facility If continuation sheet Page 17 of 125 Eacility ID: 475027 EvenLID: JB5X11

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

INTERS	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-039
TEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON			E SURVEY IPLETED C
		475027	B, WING		1	0/14/2022
		4,002,	STREE	T ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER	в	2 BLA	CKBERRY LANE NINGTON, VT 05201		
				PROVIDER'S PLAN OF COL	RRECTION	(×5)
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES ICY MUST BE PRÉCEDED BY FULL IR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIO DATE
F 655	Continued From pa	qe 17	F 655			
	from the hospital or	n 9/30/2022 after a surgical tage 4 pressure ulcer on				
	the resident is not pressure ulcer. The being "at risk for de ADL's [Activities of intervention is "PT, by physician/mid-le include how care with that the resident with review of the resident with review of the resident with the resident to "Pt 4". The resident do plan specific to helt the resident's adm 9/30/22 at 15:50 h has impaired visio and/or loosely fittin uses a walker, who	lent's care plan revealed that care planned specifically for a e resident is care planned for creased ability to perform Daily Living] however the only OT/SP treatment as ordered evel provider" and did not rould be provided or the ADL's build require assistance with. A ent's diagnosis list includes but essure Ulcer of Left Hip, Stage bes not have a base line care this mobility needs although ission assessment dated bours, revealed that the resident in requiring glasses, has broken ing full or partial dentures, and eelchair, and a limb prosthesis in o baseline care plans for uses.			s.	
	emergency respor Nurse), confirmed stage 4 pressure u is not specific to a	/22 at 2:15 PM with an use LPN (Licensed Practical that the resident does have a loer and the baseline care plan stage 4 pressure ulcer.				
	(Registered Nurse revealed that the r pressure ulcer and VAC (vacuum-as	/22 with staff RN/NPE /Nurse Practice Educator) esident does have a stage 4 d was admitted with a Wound sisted closure (VAC) is method pressure around a wound to				

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

Event ID: JB5X11

Facility ID: 475027

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			OMB NO	0.0938-0391
		MEDICAID SERVICES	(X2) MULTIPLE COM	NSTRUCTION	(X3) DATE	
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED
AND PLAN OF	CORRECTION					С
		475027	B. WING		10	/14/2022
		475027	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PI	ROVIDER OR SUPPLIER			ACKBERRY LANE		
DENNING	TON HEALTH & REHAB			NINGTON, VT 05201		
DEMMINO				REQUIDER'S PLAN OF CORE	RECTION	(X5)
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PREFIX	IT ACH CODDECTIVE ACTIONS	HOULD BE	COMPLETION DATE
PREFIX TAG	(EACH DEFICIENC REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AI DEFICIENCY)	TROFILATE	
TAG						
F 655	Continued From pag	e 18	F 655			
1 000	admitted to the facili	ty on 9/29/22 with medical				
	diagnoses of Type 2	Diabetes Mellitus Without				
	Complications From	tal Lobe and Executive				
	Function Deficit Foll	owing Cerebral Infarction,				
	Pressure Ulcer of Sa	acral Region, Stage 2,				1
	Dysphagia Orophan	yngeal Phase. An admission				
	assessment dated 9	/29/22 reflects that the				
	resident was admitte	ed with a G-Tube (a tube				
	used to provide food	d, fluid, and medications				
	directly to the stoma	ach). Physicians' orders				
		no orders for G-Tube care or				
	flushes.					
		Untonviou with Registered				
	a) 10/12/22 3:00 PM	A Interview with Registered practice educator (NPE) who				-
	Nurse (RN) Nurse p	dication cart at the time of				4
	this interview He/s	he indicates that he/she "has				
	not seen the resider	nt's G tube, and stated that				
	nursing doesn't do a	anything with it, it is not used".				
	Record review perfe	ormed with this RN at this time				
	and date confirms t	hat there are no orders for G-				
	tube site assessme	nt, no flush, and no treatment.				
	The resident's base	line care plan was reviewed				
		lan in place for the residents				
	existing G-Tube.					
	0 40/40/00 at 10:	30 am an LNA confirmed that				1
	On 10/13/22 at 10.	G-Tube and offered to assist				
	the resident who a	greed to allow surveyors to				
	Look at her/his dres	sings. The resident was				
	observed as having	g a G-tube in place.				
	10/13/22 12:58 PM	Interview with Licensed				
	Practical Nurse (LF	PN) MDS coordinator				
	confirmed that ther	e isn't treatment for the G-				
	tube in place, and t	here was not a baseline care				
	plan for the G-Tube	е.				
		an DM Observed resident door				
	b) On 10/11/22 12:	22 PM Observed resident door		16. ID: 475027	If continuation she	et Page 19 of 12
		Event ID: J	B5X11 Faci	lity ID: 475027		-

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Event ID: JB5X11

FORMAPPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A-BUILDING __ AND PLAN OF CORRECTION С 10/14/2022 475027 R WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON HEALTH & REHAB BENNINGTON, VT 05201 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 655 F 655 Continued From page 19 was closed, it has a sign on the door that had a star on it. This was confirmed at this time and date by a LNA that the sign was an indication that the resident was a fall risk. The Minimum Data Set (MDS) Assessment Reference date (ARD) 10/5/22 5-day assessment Section Care Area Assessment (CAA) indicates that resident is fall risk and will proceed with care plan. However, there is no fall risk care plan in the baseline care plan that is in place. Interview on 10/14/22 at 12:09 PM with the MDS (Minimum Data Set) Coordinator, (Licensed Practical Nurse) LPN who confirmed that the resident's admission assessment revealed the resident is a fall risk and she/he confirmed there was no fall risk care plan in place on the base line care plan for resident #204. c) Record review revealed a Physician's orders for Santyl External Ointment 250 UNIT/GM (Collagenase) that read: "Apply to Right Groin and coccyx topically everyday shift for wound care cleanse with NS and pat dry, cover with Dry protective dressing AND apply to right groin topically as needed for wound care". Admission assessment dated 9/29/22 indicates Resident was admitted with a Right groin incision dehisced, coccyx open, left, and right buttocks shearing multiple areas. The 5-day admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/5/22 Section M part A skin conditions is coded as follows; Resident has a pressure ulcer/ injury a scar over bony prominence or a non-removable dressing/ device, this was coded" NO". Section M

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Event ID: JB5X11

Facility ID: 475027

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PRINTED: 10/31/2022

PRINTED: 10/31/2022 FORMAPPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION С 10/14/2022 R: WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2 BLACKBERRY LANE** BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID. (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG F 655 Continued From page 20 F 655 0210 Unhealed pressure ulcers. Does this resident have one or more unhealed pressure ulcers/injuries coded "Yes". (A pressure injury is an area on the skin that has been damaged related to pressure). 10/13/22 12:58 PM interview with Licensed Practical Nurse (LPN) MDS Coordinator confirms that the resident does have a stage 2 pressure ulcer on her coccyx and the base line care plan does not reflect that there is a stage 2 pressure injury. There are no goals, or intervention related to the stage 2 pressure injury to prevent pressure injury from becoming worse. 3. Resident #37 was readmitted to the facility on 8/25/22 after a hospital admission with the following diagnoses: Hemiplegia and Hemiparesis following cerebral infarction affecting left non dominant side, calculus of Gallbladder and Bile Duct without Cholecystitis without obstruction, Paroxysmal Atrial Fibrillation, Cerebral infarction unspecified, Major Depressive Disorder, and Shortness of Breath. Per medical record review resident # 37 does not have a physician order for a diet. Review of Minimum Data Set (MDS) assessment reference date (ADR) 8/17/22 Section G indicates Supervision set up only Care Area Assessment (CAA) yes to proceed with nutrition problem on resident's base line care plan. Further medical record review reveals that the resident does not have a Dietary base line care plan in place. 10/14/22 at 11:54 AM interview with Licensed Practical Nurse (LPN) MDS coordinator confirms at this time that there is no base line dietary care plan in place for resident #37. If continuation sheet Page 21 of 125

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Event ID: JB5X11

Facility ID: 475027

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: С A. BUILDING AND PLAN OF CORRECTION 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** PROVIDER'S PLAN OF CORRECTION (EACH (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID. CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 656 F 656 Develop/Implement Comprehensive Care Plan F 656 Resident #5 care plan and kardex has CFR(s): 483.21(b)(1) been reviewed and updated to reflect his SS=H current status and care needs. §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and Resident #256 no longer resides at the implement a comprehensive person-centered care plan for each resident, consistent with the facility. resident rights set forth at §483.10(c)(2) and Resident #204 has had Fall, Nutrition, §483.10(c)(3), that includes measurable Pressure Ulcer/Skin care plans objectives and timeframes to meet a resident's reviewed and developed. medical, nursing, and mental and psychosocial needs that are identified in the comprehensive Resident #37 had a nutrition care plan assessment. The comprehensive care plan must developed. describe the following -(i) The services that are to be furnished to attain House audit was conducted on Person or maintain the resident's highest practicable Centered comprehensive careplans. physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and Education of the Person-Centered (ii) Any services that would otherwise be required careplan policy has been conducted with under §483.24, §483.25 or §483 40 but are not the IDT team. provided due to the resident's exercise of rights under §483.10, including the right to refuse Audits of comprehensive care plans treatment under §483.10(c)(6). will be conducted to ensure a (iii) Any specialized services or specialized comprehensive individualized care rehabilitative services the nursing facility will plan has been developed weekly X3 provide as a result of PASARR then Monthly X3 by the DON or recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its designce. rationale in the resident's medical record. (iv)In consultation with the resident and the The results of the audits will be reported resident's representative(s)and reviewed at the QAPI Committee (A) The resident's goals for admission and meeting and evaluated as indicated desired outcomes. monthly X4. Over- sight will be provided (B) The resident's preference and potential for by the DON or designee. future discharge. Facilities must document Flosh POL accepted 11/7/22 streeman Poilpure whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care

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Facility ID: 475027

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DEPARTMENT OF HEALTH AN	ND HUMAN SERVICES				APPROVED 0.0938-0391
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY PLETED
4	475027	B. WING		10/	14/2022
NAME OF PROVIDER OR SUPPLIER BENNINGTON HEALTH & REHAE	3	2 BL	EET ADDRESS, CITY, STATE, ZIP CODE ACKBERRY LANE NNINGTON, VT 05201		
	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
requirements set for section. This REQUIREMEN by: Based on observat review the facility fa a comprehensive pe assure that the resid for 4 of the 37 reside (Residents #5, #256 include: 1. Per record review focus regarding ass daily living] care in 1 hygiene, dressing, e locomotion, and toll of CHF [congestive [chronic obstructive of ADL intervention specifies the assist The care plan does assistance needed dressing, transfer, Resident #5 also h initiated on 1/6/202 that states "Reside related to [prior] co pressure areas, us use of diuretic ther CHF, recent hospit weight] change r/t intervention initiate	 a, in accordance with the rth in paragraph (c) of this IT is not met as evidenced ion, interview, and record iled to develop and implement erson-centered care plan to dent's care needs were met ents in the survey sample 5, #204, & #37). Findings v Resident #5 has a care plan sistance for ADLs [activities of bathing, grooming, personal eating, bed mobility, transfers, leting related to dx [diagnosis] heart failure] and COPD e pulmonary disease]. Review is reveal the only ADL that ance needed is ambulation. a not identify the level of staff for; bathing, bed mobility, toileting, or eating. as a care plan focus that was 22 and revised on 4/20/2022 ent may be nutritionally at risk vid recovered, hx [history] of e of mechanically altered diet, apy, obesity status, diabetes, talization with sig wt [significant [related to] diuresis' An ed on 1/6/2022 directs staff to tor intakes" and "Record and 	F 656			

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Event ID: JB5X11

DEPART	IENT OF HEALTH AN	D HUMAN SERVICES				RM APPROVED
CENTERS	FOR MEDICARE & N	MEDICAID SERVICES				TE SURVEY
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			WPLETED
AND PLAN OF	CORRECTION		A. Building			С
		475027	B, WING			0/14/2022
	OVIDER OR SUPPLIER		STR	REET ADDRESS, CITY, STATE, ZIP COD	E	
				LACKBERRY LANE		
BENNING	TON HEALTH & REHAB		BE	NNINGTON, VT 05201		1
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION	N SHOULD BE	(X5) COMPLETION
PREFIX	JEACH OFFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
TAG	REGULATORTORY			DEFICIENCY		
F 656	Continued From page	e 23	F 656			1.5
	of diabetes: non-insu	lin dependent with an				
	intervention initiated	on 1/5/2021 of monitor meal				
	consumption each m	eal."				
	Doc review of the lice	nsed nursing assistant				
	documentation for 10)/1 - 10/14/22 meal intakes				
	were not consistently	monitored per care plan.				
	There were 42 oppor	tunities to document the				i i
	assistance provided	and the percentage of the he 42 opportunities, 36 were				3
	left blank, not comple	ated.				
	Per interview with a l	Registered Nurse (RN) on				
	10/14/2022 at approx	kimately 2:45 PM regarding s/he stated that the licensed				
	the above concerns :	NAs) would find the ADL	1.			
	interventions to inclu	de assistance needed for				
	eating on the resider	t care Kardex. However,				
	while viewing the Ka	rdex the RN confirmed that				
	the care plan and Ka	rdex were not complete, and not identified on the resident				
	Kardex or care plan.	S/he also confirmed that the				
-	LNA documentation	was not complete.				
	2. Per record review	Regident # 256 was				
	2. Per record review	cility from another Genesis				
	facility 5/25/2022 wit	h a discharge summary				
	written on 5/25/2022	that states that her/his skin				
	was intact. During he	er/his stay at this facility s/he				
	has refused getting	out of bed and refused onal hygiene putting her/him				
	assistance with pers	pressure ulcers. A Nursing				
	Evaluation complete	d on 5/25/2022 indicates that			57 - S	
	the resident is a high	n risk for pressure ulcers.				
	Des services of the ser	sident's nursing progress				
	Per review of the res	on 8/21/2022 reflects that a				
	Licensed Nursing A	ssistant informed the				
	Licensed Practical N	lurse that the resident was				
		Event ID: IB:	X11 Fac	cility ID: 475027	If continuation she	et Page 24 of 125

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Event ID: JB5X11

DEPART	VENT OF HEALTH AN	D HUMAN SERVICES			OMB	IO. 0938-0391
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES	(X2) MULTIPLE CO	NSTRUCTION	(X3) DA	TE SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING		co	MPLETED
AND PLAN OF	CORRECTION					С
		475027	B. WING		1	0/14/2022
			STRE	ET ADDRESS, CITY, STATE, ZIP C	ODE	
NAME OF PI	ROVIDER OR SUPPLIER		2 BL	ACKBERRY LANE		
BENNING	TON HEALTH & REHAB		BEN	ININGTON, VT 05201		
				PROVIDER'S PLAN OF	CORRECTION	(X5) COMPLETION
(X4) ID	JEACH DEFICIENC	TATEMENT OF DEFICIENCIES	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE	DATE
PREFIX TAG	REGULATORY OR	LSG IDENTIFYING INFORMATION)	TAG	DEFICIENC	Y)	
			E 050			1 1
F 656			F 656			
	found to have an ope	en area on her/his left calf.				
	The progress notes :	states " Area red and	i			1
	draining yellow/gree	n drainage. Resident reports				
	pain in the area 7/10	area measured 4cm L by 1.5				
	administered. Open	iven to {Name omitted RN				
	(Registered Nurse) s	supervisor to f/u [follow up]				
	with PCP IPrimary c	are Physician] for				
	treatment "A progr	ess note written on 8/21/2022				- N
	reflects that an antib	iotic was ordered to treat the				40
	"new open area to L	(left) medial leg. No ill effects				15
	noted."					
		alaa waa raviewed and		¥)		
	The resident's care	plan was reviewed and s no care plan focus in place				
	that addresses the h	high risk of pressure ulcer				
	development and no	o interventions implemented			92 - C	
	to decrease or mana	age the risk or the actual				l.
	pressure ulcer that of	developed on 8/21/2022.				
1	During an interview	with the Executive Director on AM when asked if s/he	5			
	10/10/2022 at 9:30 /	by the name of [name omitted]				
	e/be said yes s/be d	lid. S/he was asked if there				
	had been review of	pressure ulcers or injuries to				
	her/his left lea durin	g morning meeting or any				
1	type of risk meeting	The ED stated "No, I don't				
	remember anything	with her/him like that." The				
	ED was asked if the	ere was any documentation				
8	related to the wound	d. The ED did not provide on to this surveyor throughout				
8						
	the survey.	v Resident # 204 was				
	admitted to the facil	lity on 9/29/22 with medical				(l)
	diagnoses that inclu	ide: Type 2 Diabetes Mellitus,				
	Frontal Lobe and E	xecutive Function Deficit				
	Following Cerebral	Infarction, Other Reduced				
	Mobility, Pressure I	Ulcer of Sacral Region, Stage				
	2, Dysphagia Orop	haryngeal Phase. Muscle		(b. 10) 475007	If continuation sh	eet Page 25 of 125
		Event ID: JB	5X11 Facil	lity ID: 475027		-

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Event ID

A DATE DATE OF A DATE OF				
	MEDICAID SERVICES			(X3) DATE SURVEY COMPLETED
CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING		С
				10/14/2022
	475027			10/14/2022
OVIDER OR SUPPLIER				
		1		
UN HEALTH & REHAD	- 1 a ²			N (X5)
SUMMARY S		ID PREFIX	FACH CORRECTIVE ACTION SHOULD	BE
REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS REFERENCED TO THE APPROPT DEFICIENCY)	NATE
		E 656		
		1 030		
	zed) Unspecified			
Convulsions.				
a) Observation on 10)/11/22 10:00 AM of Resident			
#204 revealed her/h	is breakfast tray was placed			
in front of her/him ur	supervised on the over bed			
table and had been	unopened. An attempt to			
interview Resident #	204 revealed s/he was very			
groggy and lethargic	and was not able to	-		
participate in the Inte	m door was closed and upon			
the doorframe was a	picture of a star.		χ.	
Interview on 10/11/2	2 at 12:24 PM with Licensed			
Nursing Assistant (L	NA) who confirmed the sign			
was an indication th	at the resident was a fail lisk,			
		1 1		
Review of the Minim	ium Data Set (MDS) with an			
Assessment Refere	nce date (ARD) 10/5/22,			
(5-day assessment)	, Care Area Assessment			
(CAA) revealed that	resident is a fail lisk, and the			
There was no comp	rebensive care plan in place			
for fall risk for Resid	lent #204.			
The facility fall polic	y, titled, "NSG215 FALL		~	
MANAGEMENT" ur	nder Practice Standards,			
section #2, reads "in	erventions according to			
individual risk factor	s in the patient's plan of			
care".	5000 ·			
Interview on 10/14/	22 at 12:09 PM with the MDS			
Coordinator, Licens	ed Practical Nurse (LPN) who			
confirmed the resid	ent's admission assessment nt is a fall risk, it was triddered			
on the Care Area A	ssessment (CAA), and was			
	OVIDER OR SUPPLIER ON HEALTH & REHAB SUMMARY S (EACH DEFICIENC REGULATORY OR Continued From pag Weakness (Generali Convulsions. a) Observation on 10 #204 revealed her/hi in front of her/him ur table and had been u interview Resident # groggy and lethargic participate in the inter Resident #204's roo the doorframe was a Interview on 10/11/2 Nursing Assistant (Li was an indication the stated she/he was n an actual fall risk or Review of the Minim Assessment Refere (5-day assessment) (CAA) revealed that facility will proceed that facility will proceed that facility will proceed that facility fall polic MANAGEMENT" ur section #2, reads "In patient-centered int individual risk factor care". Interview on 10/14// Coordinator, Licens confirmed the reside	IDENTIFICATION NUMBER: OVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 Weakness (Generalized) Unspecified Convulsions. a) Observation on 10/11/22 10:00 AM of Resident #204 revealed her/his breakfast tray was placed in front of her/him unsupervised on the over bed table and had been unopened. An attempt to interview Resident #204 revealed s/he was very groggy and lethargic and was not able to participate in the interview. At 12:22 PM revealed Resident #204's room door was closed, and upon the doorframe was a picture of a star. Interview on 10/11/22 at 12:24 PM with Licensed Nursing Assistant (LNA) who confirmed the sign was an indication that the resident was a fall risk, stated she/he was not sure if Resident #204 was an actual fall risk or not. Review of the Minimum Data Set (MDS) with an Assessment Reference date (ARD) 10/5/22, (5-day assessment), Care Area Assessment (CAA) revealed that resident is a fall risk, and the facility will proceed with a fall risk care plan. There was no comprehensive care plan in place for fall risk for Resident #204. The facility fall policy, titled, "NSG215 FALL MANAGEME	A. BUILDING A. BUILDING 475027 B. WING OVIDER OR SUPPLIER STR ON HEALTH & REHAB BET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 25 F 656 Weakness (Generalized) Unspecified Convulsions. F 656 a) Observation on 10/11/22 10:00 AM of Resident #204 revealed her/his breakfast tray was placed in front of her/him unsupervised on the over bed table and had been unopened. An attempt to interview Resident #204 revealed s/he was very groggy and lethargic and was not able to participate in the interview. At 12:22 PM revealed Resident #204's room door was closed, and upon the doorframe was a picture of a star. Interview on 10/11/22 at 12:24 PM with Licensed Nursing Assistant (LNA) who confirmed the sign was an indication that the resident was a fall risk, stated she/he was not sure if Resident #204 was an actual fall risk or not. Review of the Minimum Data Set (MDS) with an Assessment Reference date (ARD) 10/5/22, (5-day assessment). Care Area Assessment (CAA) revealed that resident is a fall risk, and the facility will proceed with a fall risk care plan. There was no comprehensive care plan in place for fall risk for Resident #204. The facility fall policy, titled, "NSG215 FALL MANAGEMENT" under Practice Standards, section #2, reads "Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care". Interview on 10/14/22 at 12:09 PM with the MDS Coordinator, Lice	IDENTIFICATION NUMBER: A. BUILDING 475027 B. WING OWDER OR SUPPLER STREET ADDRESS, CITY, STATE, 2P CODE ON HEALTH & REHAB STREET ADDRESS, CITY, STATE, 2P CODE SUMMARY STATEMENT OF DEFICIENCIES D READ TO PERCINCY WING TO PERCINCE OF PULL RECOLLATORY OR USCIDENTIFYING INFORMATION D Continued From page 25 F 656 Weakness (Generalized) Unspecified Convulsions. F 656 a) Observation on 10/11/22 10:00 AM of Resident #204 revealed her/his breakfast tray was placed in front of her/him unsupervised on the over bed table and had been unopened. An attempt to interview Resident #204 revealed s/he was very groggy and lethargic and was not able to participate in the interview. At 12:22 PM revealed Resident #204's room door was closed, and upon the doorframe was a picture of a star. Interview on 10/11/22 at 12:24 PM with Licensed Nursing Assistant (LNA) who confirmed the sign was an indication that the resident was at all risk, stated she/he was not sure if Resident #204 was an actual fall risk or not. Review of the Minimum Data Set (MDS) with an Assessment). Care Area Assessment (CAA) revealed that is a fall risk, and the facility will proceed with a fail risk care plan. There was no comprehensive care plan in place for fall risk for Resident #204. The facility fall policy, titled, "NSG215 FALL MANAGEMENT" under Practice Standards, section #2, reads "Implement and document patient-centred Interventions according to individual risk factors in the patient's plan of care". Interview on 10/14/22 at 12:09 PM with the MDS Coordinator, Licensed Practical Nurse (LPN) who confirmed the r

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE COM	ISTRUCTION	(X3) DATE	SURVEY
ND PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING		000	C
		475027	B. WING		10	/14/2022
MANE OF B	ROVIDER OR SUPPLIER	475021		ET ADDRESS, CITY, STATE, ZIP CODE		
12		. (°		CKBERRY LANE		
BENNING	TON HEALTH & REHAE	3	BENI	NINGTON, VT 05201 PROVIDER'S PLAN OF CORREC	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
F 656	The LPN MDS Coor no fall care plan in p Per record review R the facility with a G- revealed there are n flushes, Medical Din 10/06/22 does reve a G-tube in the hos oropharyngeal dysp dated 10/6/22, reve Resident #204: "sp Interview on 10/14/ (Certified Occupatii that the speech-lan aware of the G-tube dysphagia on resid confirmed that SLP #204. She/he state and s/he was the o this day. Review of Residem Assessment (CAA) triggered as an are additional assistan that they would pro- was no evidence of Resident #204. Interview on 10/14/ MDS coordinator of	d with care plan for fall risk. rdinator confirmed there was place for resident #204. tesident #204 was admitted to Tube. Physicians' orders no orders for G-Tube care or rector progress note dated aled that the resident required pital due to "severe phagia". A MD progress note taled the following order for eech and swallow to follow". 22 at 8:30 AM the COTA onal Therapy Assistant) stated guage pathologists (SLP) was e and the diagnosis of ents' admission. She/he thas not screened Resident d that SLP is only per diem, nly therapist in the building on t #204's Care Area) revealed Nutritional status is a where the resident required oceed with care plan. There f a nutritional care plan for /22 at 12:09 PM with the LPN confirmed that the CAA did	F 656			
	trigger for Nutrition	and Resident #204 does not place for nutrition that would				
÷.,	It > Decent reviews	on 10/12/22 04:09 PM revealed				

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES			OMB N	0.0938-0391
CENTER	S FOR MEDICARE & M	MEDICAID SERVICES	(X2) MULTIPLE CO			SURVEY
STATEMENT OF	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	A. BUILDING	NO NO NA		PLETED
		475027	B. WING			/14/2022
NAME OF PI	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP C	ODE	
				ACKBERRY LANE		
BENNING	FON HEALTH & REHAB		BEN	NINGTON, VT 05201	CORDECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE
F 656	a Physician's orders 250 UNIT/GM (Collar Right Groin and cocc wound care cleanse pat dry, cover with dr apply to right groin to care". Admission assessme resident was admitted dehisced, coccyx op shearing multiple are Unhealed pressure of this resident have on ulcers/injuries" was of admission MDS with (ARD) of 10/5/22, the (CAA) section revea they would proceed ulcer. Review of the revealed there was r pressure ulcers. Interview on 10/13/2 MDS Coordinator co M0100 A is coded in does have a stage 2 coccyx, and there is the resident's stage Review of facility po "NSG236 Skin Integ Policy" stated, "A co ongoing nursing ass extrinsic factors that skin/wound impairm wound to heal will bo	for Santyl External Ointment genase) that read: "Apply to syx topically everyday shift for with normal saline (NS) and y protective dressing AND opically as needed for wound ent dated 9/29/22 revealed d with a Right groin incision en, left, and right buttocks eas. Section M 0210 alcers was code as: "Does te or more unhealed pressure coded "Yes". The 5-day Assessment Reference Date te Care Area Assessment led the facility documented with care plan for Pressure resident's care plans no care plan in place for 22 12:58 PM with the LPN onfirmed the MDS section icorrectly, since the resident pressure ulcer on her/his no care plan that addresses	F 656			

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

Event ID: JB5X11

Facility ID: 475027

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING ._ С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON HEALTH & REHAB** BENNINGTON, VT 05201 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 656 F 656 Continued From page 28 assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed." 4. Per record review Resident #37 was readmitted to the facility after a hospital admission with the following diagnoses: Hemiplegia and Hemiparesis following cerebral infarction affecting left non dominant side, calculus of Gallbladder and Bile Duct without Cholecystitis without obstruction, and Cerebral infarction. Review of Physicians' orders reflects that Resident # 37 does not have a physician order for a diet. The Minimum Data Set (MDS) with an assessment reference date (ADR) of 8/17/22, Section G revealed the resident required Supervision and set up only. The CAA revealed the facility documented they would proceed with a care plan for nutrition for Resident's #37. Review of the resident's care plan revealed that the resident does not have a care plan in place for nutrition with goals and intervention to avoid decline. Interview on 10/14/22 at 11:54 AM with LPN MDS coordinator confirmed the facility documented they would proceed with a dietary care plan, and there is no dietary care plan in place for resident #37. F 657 F 657 Care Plan Timing and Revision Resident #256 No longer resides at F 657 CFR(s): 483.21(b)(2)(i)-(iii) SS=D the facility. §483.21(b) Comprehensive Care Plans House audit conducted on care §483.21(b)(2) A comprehensive care plan must plan timing and revision. Care plans have been revised to reflect be-(i) Developed within 7 days after completion of residents current conditions. the comprehensive assessment.

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Event ID: JB5X11

Facility ID: 475027

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PRINTED: 10/31/2022

DEPART	IENT OF HEALTH AN	D HUMAN SERVICES			OMB NO.	0938-0391
CENTERS	FOR MEDICARE & M	MEDICAID SERVICES			(X3) DATE S	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMPL	
		475027	B, WING		C 10/1	4/2022
	ROVIDER OR SUPPLIER		57	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PI	CONDER ON SUPPLIER			BLACKBERRY LANE		
BENNING	TON HEALTH & REHAB		B	ENNINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	 includes but is not lin (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pratter the resident and the resident and the resident and the resident resident resident's care plan. (F) Other appropriate disciplines as determ or as requested by the factor of the resident's care plan. (F) Other appropriate disciplines as determ or as requested by the resident's care plan. (F) Other appropriate disciplines as determ or as requested by the factor of the resident's care plan. (F) Other appropriate disciplines as determ or as requested by the factor of the resident's care plan. (F) Other appropriate disciplines as determ or as requested by the factor of the resident's care plan. (F) Other appropriate disciplines as determ or as requested by the resident's care plan. (F) Other appropriate disciplines as determ or as requested by the resident's care plan. (F) Other appropriate disciplines as determ or as requested by the resident's care plan. (F) Other appropriate disciplines as determ or as requested by the resident's care plan. (F) Other appropriate disciplines as determ or as requested by the resident resident's care plan. (F) Other appropriate disciplines as determ or as requested by the resident resident resident's care plan. (F) Other appropriate disciplines as determ or as requested of a resident resident resident resident resident resident resident resident. (F) Other appropriate disciplines include: (F) Per record review transferred to the fafacility 5/25/2022 wis intact. During has refused getting with personal hygie developing pressure. 	terdisciplinary team, that nited to ysician. e with responsibility for the responsibility for the d and nutrition services staff. acticable, the participation of resident's representative(s). the included in a resident's participation of the resident presentative is determined the development of the e staff or professionals in nined by the resident's needs he resident. vised by the interdisciplinary essment, including both the	F 657	Education provided to the ID' on care plan timing and re-vi- process. Audits will be conducted on to plan revision process to ensur- plans are revised to reflect cu- status and completion on time X3 then Monthly X3. The results of the audits will H ported and reviewed at the Q. Committee meeting and evalu- indicated Monthly X4. Overs- provided by the DON or desi FloST PDC accepted While 2000 FloST PDC accepted While 2000	sion the care re care rrent e Weekly be re- API tated as sight gnee.	unew/mme
		Event ID: 10	5X11 F	acliity ID: 475027 If conlin	nuation sheet	Page 30 of 125

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Event ID: JB5X11

DEPART	MENT OF HEALTH A	ND HUMAN SERVICES			OMBN	RM APPROVED 10. 0938-0391
STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE COM			TE SURVEY MPLETED C
		475027	B. WING		1	0/14/2022
			2 BL4	ET ADDRESS, CITY, STATE, ZIP CODE		
BENNING	TON HEALTH & REHAE			NINGTON, VT 05201 PROVIDER'S PLAN OF COR	RECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLÉTION DATE
F 657		ge 30 sk for pressure ulcers.	F 657			
	On 8/21/2022 a Lice informed the Licens resident was found her/his left calf. The red and draining yel reports pain in the a administered. Open cm W. Information g (Registered Nurse) with PCP [Primary of treatment" A prog 23:16 reflects that a treat the "new open ill effects noted. The resident's care revealed that there the high risk of pres no interventions im manage the risk or developed on 8/21/ resident's care plar were made after th regarding the care During an interview 10/10/2022 at 9:30 recalled a resident s/he said yes s/he had been review of her/his left leg duri type of risk meeting remember anything asked if s/he did he to the wound to pro-	ensed Nursing Assistant ed Practical Nurse that the to have an open area on progress notes states " Area llow/ green drainage. Resident area 7/10. Scheduled Tylenol n area measured 4cm L by 1.5 given to {Name omitted} RN supervisor to f/u [follow up]				

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Event ID: JB5X11

Facility ID: 475027

	S FOR MEDICARE 8		(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING		C
		475027	B. WING		10/14/2022
ME OF PR	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
				BLACKBERRY LANE	
NNING	TON HEALTH & REHA	В	BI	ENNINGTON, VT 05201	
	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
X4) ID REFIX	(EACH DEFICIEN	VCY MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	DATE
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	IAG	CROSS-REFERENCED TO THE	
				APPROPRIATE DEFICIENCY)	
		L.D. Considered	F 658	F 658	
F 658		Meet Professional Standards	1 000	1 058	
SS=D	CFR(s): 483.21(b)(3)(1)		Resident #40 returned from th	e
	0400 04(h)(2) Com	orshonsive Care Plans		ER on $10/3/22$ and continues t	0
	§483.21(b)(3) Com	prehensive Care Plans led or arranged by the facility,		be monitored for changes in	
	The services provid	comprehensive care plan,		condition.	
	must-			COllement.	
	(i) Meet profession:	al standards of quality.	-	Resident #54 no longer reside	s at
	This REQUIREME	NT is not met as evidenced		the facility.	
	by:			the facility.	- C
	Based on record re	eview and interview, the facility		Residents with changes in	
	failed to conduct an	nd document assessments to		condition have the potential o	f
	accurately reflect th	ne resident's status care and		being affected by the deficien	t
	services provided a	according to accepted		practice.	-
	standards of clinica	al practice for two residents		•	
	(#40 and #54) in a	sample size of 37.		Education has been provided	10
				Licensed staff on Change of	
	Findings include:			Condition Assessment and	· · · ·
		eveals that resident #54 was		documentation.	
	1. Record review r	ility on 08/09/22 and died at the		the the third on	
	facility on 09/05/22	due to acute chronic hypoxic		Audits will be conducted on	anto
	respiratory failure s	secondary to aspiration		change of condition assessme	hy hy
	pneumonitis and a	dvanced dementia per a		Weekly X3 then Monthly X3	JUY
	practitioner note (0	9/06/22). This resident had		the DON or designee.	
	the following diagn	oses: Dementia, Delirium,			
	Depression, A-fib.	Benion Prostatic Hyperplasia,	_	The results of the audits will	be –
	glaucoma, Hypoth	yroidism and Dysphagia. This		reported and reviewed at the	
	resident contracted	COVID-19 virus said to be		OAPI Committee meeting w	1th
	resolved on 07/14/	22 per a practitioner note		further evaluation if indicate	d
	(08/12/22). This wa	as a resident transferred from		Monthly X	
	another nursing ho	ome raciity.		4. Oversight will be provide	aby
	Further regions of th	he medical record indicates		the DON or designee.	
	that this resident h	ad a fall on 08/14/22. A nurse			h. Haus
	note reveale "I MA	(Licensed Nurse Assistant)		F658 POL accepted 11/7/22 SFr.	erman profeme
	reported hearing lo	oud bang while in the room			
	across the hall from	m [name omitted], when she			
	entered the room s	saw pt. laying on the floor next			
	to his bed, this nur	se entered the room after			

DEPART	MENT OF HEALTH ANI S FOR MEDICARE & N					FOF OMB N	ED: 10/31/2022 MAPPROVED O: 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE COM	ISTRUCTION		E SURVEY MPLETED
AND PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER	A; BUILDI	NG			-
							G
		475027	B. WING				0/14/2022
	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
					CKBERRY LANE		
BENNING	TON HEALTH & REHAB			BEN	NINGTON, VT 05201		
(X4) ID PREFIX TAG	JEACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 658	being notified by LNA right side next to his h top of head, neuro vit limits), VSS [vital sign [fracture] or other inju in lowest position, as Hoyer lift and two ass initial "change in com- completed for this read documentation related checks/vital signs co- medical record as on- with a head injury (no- head). The Neurolog change abruptly and "neuro checks" usual hours, then every eighours after a fall is an assessment. (Post-F- https://m-journal.com It was confirmed by f Consultant on 10/12 was no documentativ assessments in reside 2. Upon record revier 10/14/22, it was four transferred to the ho- hypoglycemia (low bar hospital discharge re Vermont Hospital. T assessment had bee change in this resided resident's return from there was no assess health status at that	and saw pt. laying on his bed, small abrasion noted to al signs WNL (within normal ns stable), no indication of fx ary, floor mats in place, bed sisted back to bed with sist". There is evidence of an dition SBAR assessment" sident, however further ed to neurological uld not be found in the ne would expect for a patient bited above-abrasion to top of ical status of a resident can suddenly, so ensuring that lly every hour for at least four th hours for the first 24 n important nursing fall Care Nursing Algorithm)	F	658			Dane 33 of 125

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Facility ID: 475027

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CENTERS	S FOR MEDICARE & N	IEDICAID SERVICES	1		B NO. 0938-039 DATE SURVEY
TATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		C
		475027	B. WING		10/14/2022
	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CODE	
				LACKBERRY LANE	
BENNING	TON HEALTH & REHAB		BE	NNINGTON, VT 05201	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658		9 33 09/29/22 and 10/05/22.	F 658		
	diagnosis list that incl Stage Renal Disease Hypertension, History Coronary Artery Dise	y of MI (heart attack), ase, Diabetes, and multiple unresponsive episodes and			2
	sister facility confirmed that this resident's me medical assessment progress notes on 10 was transferred to the change in condition, assessment after the emergency room, an	ng Services (DNS) from a ed on 10/14/22 at 2:45 PM edical record revealed no was entered into the EMR 0/03/22 when the resident e hospital for an acute there was no follow up resident returned from the d no nursing note was a progress notes regarding			
F 686	(9th ed). Wolters Klu Williams & Wilkins, p Treatment/Svcs to P	t Manual or Nursing Practice wer Health/Lippincott ig. 17. revent/Heal Pressure Ulcer	F 686	F 686	
SS=H	§483.25(b) Skin Inter §483.25(b)(1) Press Based on the compre- resident, the facility r (i) A resident receive professional standar pressure ulcers and	grity ure ulcers. ehensive assessment of a		Resident #5 care plan has been updated to accurately reflect curre skin conditions as well as risk factors identified with interventio updated. Dietician has seen the resident and completed a weight loss assessment and care plan has been updated.	ns

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A, BUILDING AND PLAN OF CORRECTION С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** PROVIDER'S PLAN OF CORRECTION (EACH (X5)SUMMARY STATEMENT OF DEFICIENCIES COMPLETION DATE D CORRECTIVE ACTION SHOULD BE PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG Resident #14 has a treatment order F 686 Continued From page 34 in place and an incident report has F 686 demonstrates that they were unavoidable; and been completed. (ii) A resident with pressure ulcers receives necessary treatment and services, consistent Resident #256 no longer resides in the with professional standards of practice, to facility. promote healing, prevent infection and prevent new ulcers from developing. Resident #204's MDS has been This REQUIREMENT is not met as evidenced modified to include stage 2 pressure by: injury and a care plan has been Based on observation, interview, and record developed. Treatment is being review the facility failed to ensure that 5 of 7 completed as ordered. residents reviewed for pressure ulcers (Residents #5, 14, 45, 256, and 204) received necessary Resident #52 Midline IV catheter has treatment and services consistent with been discontinued 10/29/22. Negative professional standards of practice, to promote Pressure Wound treatment has been healing, prevent infection and prevent new ulcers changed per physician order. from developing. 1. Per record review of three Skin & Wound Residents with skin breakdown or Evaluations completed on 10/6/2022 reflects that alterations have the potential to be Resident #5 has three inhouse acquired stage 2 affected by the deficient practice. pressure ulcers that include a 0.5 cm2 area, 1.0 cm Length, 0.8cm width, 0.2cm depth stage 2 Education will be provided to the pressure ulcer on her/his coccyx, a 3.0 cm2 area, Nursing staff regarding Pressure Ulcer 3.3cm Length, 1.2 width stage 2 pressure ulcer prevention with a knowledge check. on her/his right buttock, and a 0.4 cm [squared] area, 1.4cm length, 0.8cm width stage 2 pressure Education will be provided to area on her/his left buttock. Licensed Nursing staff on the Skin Integrity Management policy There is a care plan focus of "[Name omitted] is at risk for skin breakdown related to limited NSG236. mobility, muscle weakness, and chronic pain. ***Has chronic recurrent MASD (moisture related skin damage inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage) areas bilateral buttocks. 5/26/2022 chronic recurrent MASD buttocks wounds are re-open. 9/26/2022 Coccyx newly reopened and 10/6/2022 Coccyx resolved. A care plan goal states [Name If continuation sheet Page 35 of 125 Facility ID: 475027 Event ID: JB5X11 FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON HEALTH & REHAB** BENNINGTON, VT 05201 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Audits will be conducted on skin F 686 F 686 Continued From page 35 integrity management to include Skin omitted] will not show signs of skin irritation or condition identification, Careplan breakdown through next review period, and completion, Treatment ordered and 9/12/2022 [Name omitted] continues to have completed as ordered, dietary chronic open wounds" revised on 10/10/2022. notification, MDS assessment Interventions include "Daily dressing change to accuracy, Negative Pressure Therapy bilateral buttocks, cleanse wounds, place calcium treatment completion and IV dressing alginate and sure view dressing." and treatment completed as ordered. "Treatments as ordered". A Physicians order for Weekly X3 then Monthly X3. cleanse buttocks wounds (MASD) with Wound Cleanser apply calcium alginate to wounds, skin The results of the audits will be prep surrounding skin and cover with Derma view reported and reviewed at the QAPI Transparent Dressing Daily and PRN (as needed) Committee Meeting Monthly X4 Apply Transparent Dressing so that there are no further evaluation if indicated. bridges, gaps, or air spaces. every day shift for Oversight will be provided by the MASD AND as needed for dressing soiled or DON or designee. comes off. F686 POL accepted 11/7/22 Streeman Par/ Pome During observation of incontinence care on 10/9/2022 at approximately 10:00PM Resident #5 was laying on their back in bed, the Licensed Nursing Assistant asked her/him to roll to the left and removed the resident's brief exposing her/his buttocks. There was an open redden wound on both right and left buttocks and a pink and red coccyx, there was no dressing in place. There was no evidence in the brief that there had been a dressing that had fallen off. Per interview with the Licensee Practical Nurse on 10/9/2022 at approximately 10:20 PM s/he was not aware of any wound or treatment ordered. S/he stated that the nurse that s/he relieved may have done a dressing, but s/he did not have it on her/his list. Resident #5 has also experienced a severe (greater than 10%) weight loss of 14.1% over a six-month period that was not identified and/or addressed. If continuation sheet Page 36 of 125 Facility ID: 475027 Event ID: J85X11 FORM CMS-2567(02-99) Previous Versions Obsolete

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES			OMB N	0.0938-0391
	S FOR MEDICARE & M	MEDICAID SERVICES	(X2) MULTIPLE COM	STRUCTION	(X3) DAT	ESURVEY
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING		CON	PLETED
AND PLAN OF	CORRECTION		A BOILDING			С
		475007	B. WING		10	/14/2022
		475027		ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	ROVIDER OR SUPPLIER			ACKBERRY LANE		
DENNING	TON HEALTH & REHAB			NINGTON, VT 05201		
BENNING			BEN		CTION	(X5)
(X4) ID PREFIX TAG	IEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	COMPLETION DATE
F 686	Continued From page	e 36	F 686			
	(RD) was asked about resident #5's weight leffects the prevention ulcers. S/he stated the	AM the Registered Dietician ut concerns related to loss as nutritional status n and healing of pressure nat s/he is aware of Resident and the resident "is on liquid				
	in house acquired we 10/10/2022, and exp of the wound. A Nurs 7/27/2022 identified high risk for pressure 9/10/2022 an assess states "A skin check skin injury/wound(s) and were evaluated Associated Skin Dar buttocks" A progress Practical nurse (LPN states "Pt. [resident] There are 2 purple a [Name omitted], RN and looked at [her/hi at this time. The are was positioned off th	Resident #14 developed an ound that was identified on erienced a delay in treatment sing Evaluation completed on the resident as being very a cleer development. On sment note was written that was performed, the following were previously identified as follows: MASD-Moisture mage(s): Location(s): a note written by a licensed I) on 10/10/2022 at 11:33 PM coccyx is open and bleeding. reas with redness all around. (Registered Nurse) came is wound. No treatment order a was kept clean and dry. Pt he area, from side to side."				
	10/12/2022 at 2:20 F assistant (LNA) beg brief the resident sta as the LNA pulled th resident said "ouch, was a beefy red ope buttock with no dress of thick white paste	PM as the licensed nursing an to remove resident #14's ated "oh, don't hurt my hiney!" the brief away from her skin the ouch, ouch that hurts!" There en wound noted on the right using covering it and a patch covering an open area on the A there should be a dressing			continuation she	

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PRINTED: 10/31/2022 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION С 10/14/2022 8. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON HEALTH & REHAB BENNINGTON, VT 05201** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 1D (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG F 686 F 686 Continued From page 37 over it and the thick white paste was not what should be used on the wounds. When exiting the room, the LNA asked if I would ask the nurse to come to the room to see the wound. Per Licensed Practical Nurse (LPN) there was no treatment ordered but s/he would go and look at it. Aprogress note written on 10/12/2022 at 16:21 states "Pt [patient] remains alert [with] confusion. Pt noted [with] open areas to left and right buttocks. Area cleansed [with] saline and pat dried. pt. repositioned to I side. communication left [regarding] need for wound care consult/orders." On 10/12/2022 at 2:35 PM during an interview with the RN who was identified in the above note written on 10/10/2022, s/he stated "I think that I had heard something about [the Resident] having a pressure ulcer in morning meeting but I'm not sure." On 10/13/2022 during record review it was noted that there was no evidence of physician notification of the wound, any treatment, or other interventions in place after the identification of the wounds. There had also been no weekly skin checks documented since 9/10/2022. Per interview with the Unit 2 Nurse Manager (UM) on 10/13/2022 at approximately 10:15 AM confirmation was made that there was no treatment in place for the pressure ulcer that had been identified on 10/10/2022. At approximately 11:00 AM the UM informed this surveyor that a skin evaluation had been complete and a physician's order to cleanse the area to coccyx and apply Opti foam was obtained. 3. Per record review Resident # 256 was transferred to the facility from another Genesis facility 5/25/2022 with a discharge summary written on 5/25/2022 that states that her/his skin

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Event ID: JB5X11

Facility ID: 475027

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ENTER	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			OMB NC	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			LETED
DPLANO	COMPENSION		B, WING			C 14/2022
		475027		ET ADDRESS, CITY, STATE, ZIP CODE		
AME OF P	ROVIDER OR SUPPLIER			ACKBERRY LANE		
ENNING	TON HEALTH & REH	AB		NINGTON, VT 05201		
(X4) ID PREFIX TAG	JEACH DEELCI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	JULD BE	(X5) COMPLETIC DATE
F 686	was intact. During has refused gettin with personal hyg developing pressi completed on 5/2 resident is a high On 8/21/2022 a L informed the Lice resident was four her/his left calf. T red and draining y reports pain in the administered. Op cm W. Informatio (Registered Nurs with PCP [Primar treatment" A pr at 23:16 reflects d treat the "new op ill effects noted." The resident's ca revealed that the the bigh risk of p	her/his stay at this facility s/he ig out of bed and assistance lene putting her/him at risk for ire ulcers. A Nursing Evaluation 5/2022 indicates that the risk for pressure ulcers. icensed Nursing Assistant nsed Practical Nurse that the d to have an open area on he progress notes states "Area rellow/ green drainage. Resident e area 7/10. Scheduled Tylenol en area measured 4cm L by 1.5 n given to {Name omitted} RN e) supervisor to f/u [follow up] y care Physician] for ogress note written on 8/21/2022 hat an antibiotic was ordered to en area to L (left) medial leg. No re plan was reviewed and re is no care plan that addresses ressure ulcer development and	F 686			
	no interventions manage the risk developed on 8/2 the Executive Di when asked if s/I [name omitted] a was asked if the ulcers or injuries meeting or any ty stated "No, I don her/him like that, any documentat	mplemented to decrease or or the actual pressure ulcer that 1/2022. During an interview with rector on 10/10/2022 at 9:30 AM ne recalled a resident named nd s/he said yes s/he did. S/he re had been review of pressure to her/his left leg during morning ype of risk meeting. The ED 't remember anything with " When asked if s/he did have on related to the wound to surveyor. The ED did no provide ation to this surveyor throughout	c			

Event ID: JB5X11

Facility ID: 475027

	MENT OF HEALTH AN	ID HUMAN SERVICES			OMB NO.	APPROVED 0938-039
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SI COMPLE	
		475027	B. WING	10 11 mmm	-	4/2022
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE ACKBERRY LANE		
BENNING	TON HEALTH & REHAB			NINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	9/30/2022 at 15:50 r omitted] was admitte ambulance stretcher obtained Patient Chi Special Treatment P note dated 9/30/202 pressure wound Sta Location: Left Thigh today." A Nurses No revealed, "[pronou pressure injury note an above the knee a Resident will require three days a week o Wednesday Friday] time." A Nursing As at 15:50, page 5 of mental status was " "unimpaired", her/hi "sadness/Depressio "Appropriate". Page had a skin impairme site was documente left thigh". A "Skin noted in the residen she/he had a pressi (full thickness skin a present on admissi listed as "Area 32.2 5.0 cm, and Depth and a dressing was "Primary Dressing" Pressure Wound Th "General" dated 10 ,"Alert/oriented/Plei	ed "Admission Note", dated evealed, "[proper name ed to 205-B. Arrived by information upon admission art Reason for admission is program". An assessment 2 at 17:10 revealed, "A new ge 4 presented on admission (Lateral) was assessed ote dated 9/30/2022 at 17:52 in omitted] does have a d to left thigh. Resident has imputation to right leg. wound care to left thigh in M-W-F [Monday using a wound vac at this sessment dated 09/30/2022 15 revealed the residents alert", her/his memory was	F 686			

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION C 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 686 Continued From page 40 F 686 skilled services for I thigh wound w/ wound vac, wound infx [infection]. .. " and "Wound vac in place. [pronoun omitted] continues on iv [intravenous] abx [antibiotic] for wound infx w/ good results." A Nurses Note, titled, "notification note", on 10/12/22 at 5:51 PM, revealed "Primary Chief Complaint: Lines / Tubes / Pump Issues: Wound Vac Issue" and a summary, "Patient currently has a wound VAC and is receiving IV antibiotics. The wound VAC has failed and they are currently awaiting delivery of supplies however [pronoun omitted and incorrect] currently does not have any dressing. Staff is requesting an order for appropriate dressing to be applied." A Nurses Note, titled, "General" on 10/12/2022 at 07:53 revealed, "Slept in long naps\No c/o [complaint] pain during night/Dressing to left thigh intact (I)." A Nurses Note, titled, "General" dated 10/12/2022 at 20:22 revealed, "[physician's name from telehealth contractor services omitted] ordered a more appropriate dressing be applied until the wound vac supplies arrive. The dressing is Maxorb II in wound covered with Optifoam changes q3 [every 3] days and PRN [as needed]." Review of Resident #52's TAR (Treatment Administration Record) for the 10/1/2022 -10/31/2022 period, revealed the following order: "Negative Pressure Wound Therapy to LLE SET Unit to 125 mmHg specify CONTINUOUSLY Cleanse with (NSS/Wound Cleanser/other) Place black foam into wound. Apply skin prep to intact skin around the wound Cover with occlusive dsg and secure tubing per manufacturer guide every day shift every Mon, Wed, Fri for Debrided Stage IV [4] PU [pressure ulcer] surgically Debrided prior to admission -Start Date- 10/3/2022 0700". Entries for the NPWT dressing change should have been documented on Friday 10/7/22,

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FORMAPPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION C 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG F 686 Continued From page 41 F 686 Monday 10/10/22, Wednesday 10/12/22, and Friday 10/14/22. The only documentation for the NPWT dressing change was dated on Monday 10/3/22 and Wednesday 10/5/22. The following new order revealed: "apply temporary dressing until wound vac supplies arrive: pack wound with Maxorb II Ag and cover with Optifoam change q3days [every 3 days] and PRN [as needed] every day shift every 3 day(s) for Wound care Discontinue when wound vac supplies arrive. -Start Date- 10/15/2022 0700". Interview on 10/12/22 at approximately 11:30 AM, with RN/NPE, who was working as a floor nurse on this date revealed that the residents dressing failed "last Friday", which would have been 10/7/22. She/he stated that she/he had already called and notified the doctor that the dressing had failed and requested a temporary order for a dressing until the supplies for the residents wound vac were received. Review of the resident MAR (Medication Administration Record) revealed the following order: "Biopatch on Midline, change with weekly and prn dressing changes one time a day every 7 day(s) for IV Care - Start Date- 10/1/2022 0900" This order was noted to be signed off as having been completed on 10/8/22, however, the Biopatch is applied around the Midline IV at the entrance site of the body and was covered by a dressing - the dressing was dated 9/29/22. The following order was also noted on the same MAR: "IV: Change Catheter Site Transparent Dressing. Indicate external catheter length and upper arm circumference (10 cm above antecubital space), Notify practitioner if the external length has changed since last measurement as needed for IV Care -Start Date- 09/30/2022 1706".

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 BENNINGTON HEALTH & REHAB PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 686 Continued From page 42 F 686 Interview on 10/14/22 at approximately 2:30 PM, with Resident #52, who was alert and oriented to person, place, time, and situation. She/he confirmed that her/his wound vac dressing was last changed on "last Friday", 10/7/22. The resident did have a dressing in place to her/his left posterior thigh that was quite saturated and had been leaking onto her/his bed linens. This was confirmed by the travel nurse that accompanied this writer to Resident #52. The resident was also noted to have a midline IV in her/his left upper arm, that was covered by dressing that appeared soiled and was grayish in color and was dated 9/29/22 - Resident #52 confirmed that her/his midline IV dressing was last changed at the hospital, prior to coming to this facility. The travel nurse confirmed that the Midline dressing was dated 9/29/22 and "did not look very clean". The travel nurse stated that for the Biopatch to have been changed, the outer dressing would had to have been removed to access the Biopatch since the Biopatch is placed around the Midline IV, at the entrance where the Midline IV enters the upper arm and the outer dressing is the one that was dated 9/29/22. Therefore, the Biopatch had not been changed since admission to this facility and the outer dressing had not been changed since admission to this facility. 5. Per record review Resident # 204 was admitted to the facility on 9/29/22 with medical diagnoses of Non-ST Elevation (NSTEMI) Myocardial Infarction, Type 2 Diabetes Mellitus Without Complications, Acute Pulmonary Edema, Frontal Lobe and Executive Function Deficit Following Cerebral Infarction, Other Reduced Mobility, Pressure Ulcer of Sacral Region, Stage

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON HEALTH & REHAB** BENNINGTON, VT 05201 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 686 F 686 Continued From page 43 2. Dysphasia Oropharyngeal Phase. Muscle Weakness (Generalized) Unspecified Convulsions (Not all inclusive). Record review on 10/12/22 reveals a Physician diagnosis of Pressure Ulcer of Sacral Region, stage 2. Physician orders reflect order for Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to Right Groin and coccyx topically every day shift for wound care cleanse with NS and pat dry, cover with dry protective dressing AND apply to right groin topically as needed for wound care. Unable to find measurements/description of the coccyx wound in the medical record. Review of medication administration record (MAR) reveals Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to Right Groin and coccyx topically everyday shift for wound care cleanse with NS and pat dry, cover with Dry protective dressing and Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to right groin topically as needed for wound care. The above treatment for the month of Oct 2022 There were no nurse initials for the dates of 10/6/22 and 10/7/22, 10/10/22, 10/11/22. Which indicates the treatment was not done on those dates, 10/1/22 was initialed but coded as unknown 10/12/22 was coded see nurse note. Progress notes of 10/12/22 at 1940 (7:40 PM) reflects that the resident refused a number of time and treatment was not administered. The Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/5/22 Section M- A skin conditions is coded as follows; Resident has a pressure ulcer/ injury a scar over boney prominence or a non-removable dressing/ device, If continuation sheet Page 44 of 125

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Event ID; JB5X11

Facility ID: 475027

EPARIN	IENT OF HEALTHAN	ND HUMAN SERVICES			OMB NO.	
TEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI COMPLI	ETED
		475027	B, WING		10/14	4/2022
		4/5027		REET ADDRESS, CITY, STATE, ZIP CODE		
	OVIDER OR SUPPLIER	l .	2 8	BLACKBERRY LANE ENNINGTON, VT 05201		
(X4) ID PREFIX TAG	/EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE
F 686	pressure ulcer press completetion. Section ulcers. Does this resume unhealed pressure of Care plan has no pre- ulcer to provide goal encourage heeling of from becoming wors interview with Licen MDS Coordinator C M0100 A is coded in that the resident do ulcer on her coccyx reflect that there is Free of Accident.Hat CFR(s): 483.25(d)(§483.25(d) Accident The facility must en §483.25(d)(1) The supervision and as accidents. This REQUIREMED by: Based on observa- review the facility face	". However there was a ant at the time of the MDS on M 0210 Unhealed pressure sident have one or more ulcers/injuries coded "Yes". oblem for a stage 2 pressure ls, and interventions to or to prevent pressure ulcer se. On 10/13/22 at 12:58 PM, sed Practical Nurse (LPN) onfirms that the MDS section neorrectly the Nurse confirms es have a state 2 pressure and the care plan does not a stage 2 pressure ulcer. zards/Supervision/Devices 1)(2) ts. sure that - esident receives adequate sistance devices to prevent NT is not met as evidenced tion, interview, and record ailed to ensure 1 out of 35 were safe from accident	F 686	F689 Resident #49 Afrin Nasal s has been discontinued. Nystatin order in place to a needed twice daily. Medications have been ren the bedside. All Residents have the pot affected by this deficient p House audit conducted to medications are not left a bedside for patients who assessed to be self-medic Education provided to th	pply as noved from ential to be practice. ensure t the are no ating. e Licensed	
	resident #49's envi	10/10/22 at 11:00 AM of ronment, on the resident's over was a container labeled		staff on not leaving medi the bedside and delegation medication	cations at	

Event ID: JB5X11

ENTER	S FOR MEDICARE & M	MEDICAID SERVICES		CONSTRUCTION	(X3) DATE S	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPL	
		475027	B. WING		-	4/2022
		475027		REET ADDRESS, CITY, STATE, ZIP CODE		
AME OF PR	ROVIDER OR SUPPLIER			BLACKBERRY LANE		
ENNING	TON HEALTH & REHAB			ENNINGTON, VT 05201		
040.15	AUD SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S	RECTION HOULD BE	(X5) COMPLET
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE
				application or administrat	ion.	
F 689	Continued From page		F 689			
	Nystatin powder and	a container labeled Afrin		Audits will be conducted	to ensure	
	Nasal spray.			medications are not left a	t the bed side	
		2 at 11:10 AM resident #49		and medication administr	atton of	
	Interview on 10/10/2	s unable to take these		application is not delegat inappropriately Weekly	x3 then	
	medications indepen	dently, s/he stated the Afrin		Monthly X3.		
	Spray is for nose ble	eds s/he has been		Wonting As.		
	experiencing. S/he s	tated that		The results of the audits	will be re-	
	s/he is still using the	nasal spray and that the staff		ported and reviewed at t	he QAPI	
	apply the powder to	nis/ner skin.		Committee Meeting with	n further	
	Record review revea	led the following order:		evaluation as indicated N	Aonthly A	
	"Dose check cannot	be performed. The unit of		4. Oversight will be pro-	vided by	
	measure selected do	es not match the medispan		DON or designee.		
	recommended unit o	f measure for this		F689 POC accepted 11/7	22 SFreeman	Real PRA
	medication. Nystatin	External Powder 100000 Topical)Apply to Skin folds				
	topically as needed	or Apply twice daily as				
	needed to skin folds	with fungal rash".				
	No order for Afrin sp	ray was found on current				
	physician orders. Re	view of the October 2022				
	Medication Administ	ration Record (MAR)				
	revealed the following	ig order: "Afrin Sinus nasal h nostrils three times a day				
	for epistasis x 3 day	s." The start date of this				
	order was 10/6/22 th	ere were 9 administrations of				
	this medication. The	stop date of this order				
	was10/9/22, and the	re is no order in place to				1
	have medications at	bed side.				
	Interview and MAR	review on 10/12/22 1510 with				
	Registered Nurse (F	(N) specific to leaving				
	Nystatin at the bed s	side, s/he stated that s/he has				
	the LNA apply when	they are doing care. The RN atin powder requires an MD				
	confirmed that Nyst	ould not be directed to apply				4
	this medication. The	MAR and Physician orders				
	ware reviewed with	this RN who confirmed the				

DENITEDO	FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 093	
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING			
					С	
		475027	B, WING		10/14/20	22
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE OF THE				2 BLACKBERRY LANE		
BENNING	ON HEALTH & REHAE			BENNINGTON, VT 05201		
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F 689	Continued From page		F 689			
	also confirmed that	ontinued on 10/9/22. The RN the Afrin nasal spray should le as there is no Physician				
	Nutrition/Hydration S CFR(s): 483.25(g)(1		F 692	F 692 Resident #9 no longer resides	in the	
	6/83 25(a) Assister	I nutrition and hydration.		facility.		
	(Includes naso-gast	ric and gastrostomy tubes, andoscopic gastrostomy and scopic jejunostomy, and		Resident #5 Order for weight followed Feeding assistance	addresse	
	enteral fluids). Base	ed on a resident's essment, the facility must		in care plan and Kardex Intak documentation is completed.	.c .	
	§483.25(g)(1) Main of nutritional status, desirable body weig balance, unless the	tains acceptable parameters such as usual body weight or ght range and electrolyte resident's clinical condition his is not possible or resident		Resident #18 Order for weigh being followed as permitted Resident. Feeding assistance addressed on care plan and k Intake documentation is bein completed.	by is Cardex.	
	§483.25(g)(2) Is off maintain proper hyd	ered sufficient fluid intake to fration and health;		Resident #37 Diet order is ir Intake has been documented Residents feeding assistance has been care planned and a	and need	
	there is a nutritional provider orders a th	ered a therapeutic diet when problem and the health care erapeutic diet.		All Residents have the potent		
	by: Based on observat	NT is not met as evidenced		affected by this deficient pra	ctice.	
	residents in the san #37) recieved ade assessment, and m to meet prevent sig	illed to ensure that 4 of 7 nple (Residnet #9, #5, #18, & quate assistance, nonitoring of nutritional status nificant weight loss and e parameters of nutritional		House audit conducted of we orders and completion of obt weights as ordered. Intake documentation Nutrition car and Kardex eating assistance	e plans	

DEPARTA	MENT OF HEALTHAN	D HUMAN SERVICES				0938-0391
		MEDICAID SERVICES	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE S COMPL	
	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING			
					(
		475027	B. WING		10/*	4/2022
NAME OF DE	OVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
				ACKBERRY LANE		
BENNING	TON HEALTH & REHAB		BEI	NNINGTON, VT 05201		
04010	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO	OLD BE	(X5) COMPLETION
(X4) ID PREFIX	JEACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APPR	OPRIATE	DATE
TAG	REGULATORY OR			DEFICIENCY)		
					200 - 14 (no. 75)	
F 692	Continued From page	e 47	F 692	Education has been provi	ded to	
1 001	oonandoo manipi o			nursing staff regarding ob	taining	
	1. Por record review	Resident #9 was admitted		and documenting weight	process	
	n 2/17/2022 with di	agnoses that include adult		and procedure along with		
	failure to thrive and c	cerebral palsy. An admission		significant weight change	e	
	weight of 94 5lbs was	s documented on 3/18/2022.		management.		
	Review of weekly we	eights documented between	- A.	-		
	3/18/2022 and the la	st documented weight on		Education has been conc	lucted with	
	7/11/2022 the reside	nt had experienced a severe		the LNA staff regarding		
	weight loss of 18.1%	. There is no evidence of		documentation of Intake	with all	
	weights being obtain	ed after 7/11/2022.		meals consumed.		
					and with	
	A care plan focus rei	flects that "[name omitted]		Education has been cond	ucted with	
	may be nutritionally	at risk related to severe		the Licensed Staff and D	ietician	
	protein-calorie maln	utrition, dysphasia, and adult		regarding care planning c	T	
	failure to thrive, low	body weight/BMI, use of				
	mechanically altered	diet, total dependence for		Nutritional needs and eat	ing support	1
	food/fluid intake." Ca	are plan goals include "[name	4			6
	omitted] will consum	le [greater than]50% at all		Audits of resident weigh	ts, intake	
	meals through the n	ext review period." and		documentation, nutrition	al care	
	"Maintain weight of a	82.4# with no significant wt		plans and eating support	will be	
	[weight] loss thru ne	xt review" and "Weight gain		conducted Weekly X3 th	ien Monthl	N.
	would be beneficial	for resident, and [name ne [greater than] 75% of		X3.		1
	omitted] will consult	ents daily through next				
	review."	and daily through home		The results of the audits	will be	(G)
	review			reported and reviewed a	it the QAPI	6
	A Diotory pote writte	n by the previous Registered		Committee Meeting Mo	onthly X	
	Diotician on 5/27/20	22 at 2:07 PM states "Weight		4 furtherevaluation as in	dicated.	
	monitoring: reweigh	t obtained and resident		Oversight will be provid	led by the	
	current wt 77 9# Th	his represents a 2.1#/2.6% wt		DON or designce.		
	decrease x 30 days	and an overall decrease of		_		n o lí
	6 6#/7.8% since adr	mission in March. [S/He] has		F692 POL accepted 11/7/2	2 SFreeman	n Ris IPM
	nutrition intervention	ns in place currently to			- <i>1928-2403</i> (1934)	11
	promote kcal/protei	n intake. [Her/His] intakes				1
	while variable appe	ar to be at his baseline.				
	Reviewed available	advanced directives which				1
	indicate an interest	in short-term feeding tube.				
	Attempted to have of	discussion with [Resident] to				
	and the second sec	owever [s/he] is asleep at this				

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Event ID: JB5X11

	MENT OF HEALTH AN	D HUMAN SERVICES			FORM OMB NO.	10/31/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE S COMPL	ETED
		475027	B. WING		C 10/1	; 4/2022
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE		
	TON HEALTH & REHAB			ACKBERRY LANE		8
BEINING				PROVIDER'S PLAN OF CORRECTI	ON	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	COMPLETION DATE
F 692	time after eating lunc nurse. Left message reattempt to determin desire." There are no notes to indicate follon nutritional status. On 5/27/2022 the So wrote a note stating [resident's] health ca feeding tube for shor reviewed Advanced speak to resident ho asleep. SS and Nurs [her/him] about [her/ conversation with re SS will reach out to and soon to be POA time is able to make needs, unless [s/he] Health Care proxy to [her/him]." Review of Resident documented betwee resident had been e loss of 17.57%, not had documented. TT 7/11/2022 revealed experiencing a seve the 4 months residin been no weights ob been no Dietary not weight loss or follow feeding tube docum Per phone interview 09:27 AM s/he is ne	h. Discussed with floor for social services. Will ne if this is still [her/his] of urther documented dietary ow up on the resident's orial Service (SS) Director "Spoke with Dietitian about are wishes for wanting a t time due to weight loss. SS Directivities. SS went to wever resident was fast as Manager will talk to his] wishes/wants. After that sident occurs with resident, (her/his] Health Care proxy to update. Resident at this [her/his] own health care states [s/he] wants [her/his] o make the decision for #9's weekly weights en 3/18/2022 and 5/27/22 the xperiencing a severe weight the 7.8% that the dietician he last documented weight on that the resident had been re weight loss of 18.1% over ng in the facility. There have tained since, and there have es addressing this severe v up related to the use of a tented since 5/27/2022. with the RD on 10/14/22 at tw to this position since ated that if there is an issue	F 692	lily 1D: 475027 [f cor	ntinuation sheet (Page 49 of 125

		D HUMAN SERVICES AEDICAID SERVICES		-	PRINTED: 10/3 FORMAPPR OMB NO: 0938	ROVED 3-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMFLETED	(
		475027	B. WING		10/14/202	.2
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE		
				ACKBERRY LANE		
BENNING	TON HEALTH & REHAB		BEN	NINGTON, VT 05201	TION	×5)
(X4) ID PREF1X TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE COMP	ATE
F 692	Continued From page identified related to re Managers would read consult. reviews well resident is at risk s/he Confirmed that based considered at nutritio no documented weig 2. Per record review severe (greater than over a six-month peri weight record reveale 4/1/2022 was 248.5 I recorded weight was loss over 6 months. A care plan focus of assistance for ADL [in bathing, grooming, eating, bed mobility, toileting related to dx [congestive heart fail obstructive pulmona only ADL addressed interventions is ambin not identify the level for eating. A care plan focus ini revised on 4/20/2022 be nutritionally at rist recovered, hx [histor mechanically altereco	e 49 esident's weights the Unit ch out to her/him for a ghts monthly and if the e would review weekly. d on her/his BMI he would be nal risk and that there was ht since July 11, 2022. Resident #5 experienced a 10%) weight loss of 11.7% od. Review of the resident's ed the recorded weight on bs. and on 10/3/2022 the 221lbs, a 27.5 lb. weight "[Name omitted] requires activities of daily living] care personal hygiene, dressing, transfers, locomotion, and [diagnosis] of CHF lure] and COPD [chronic ry disease]." However, the under the care plan ulation. The care plan does of staff assistance needed tiated on 1/6/2022 and 2 states that "Resident may k related to [prior] covid y] of pressure areas, use of l diet, use of diuretic therapy,	F 692	DEFICIENCY		
	change r/t [related to initiated on 1/6/2022 monitor intakes" and	b] diuresis' An intervention directs staff to "Record and I "Record and monitor 5 also has a care plan focus	5X11 Facili	ly ID: 475027 If a	ontinuation sheet Page 5	50 of 125

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO, 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/GLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION С 10/14/2022 R WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 692 Continued From page 50 F 692 initiated on 1/5/2021 of [Name omitted] has a diagnosis of diabetes: non-insulin dependent with an intervention initiated on 1/5/2021 of monitor meal consumption each meal. Per phone interview with the consulting Registered Dietician (RD) on 10/14/22 at 9:35 AM s/he started consulting in September of 2022. When asked if s/he was aware that the resident has had a 11.7% weight loss in six months s/he stated "yes, I was going to do [her/his] quarterly review today." When asked how staff communicated high risk residents or weight concerns to her/him, s/he stated "I gave them a list of weights that I was missing and asked if there were any nutritional risks. There was nothing that they noted as a concern when I sent the email." The RD confirmed that she had not been notified of any concerns related to Resident #5's weight loss or nutritional status. The RD was asked about concerns related to resident #5's pressure ulcers and s/he stated that s/he is aware of pressure ulcer concerns and the resident "is on liquid proteins." Per review of the licensed nursing assistant documentation for 10/1 - 10/14/22 there were 42 opportunities to document the assistance provided and the percentage of the meal consumed. Of the 42 opportunities, 36 were left blank, not completed. Per interview with the MDS (Minimum Data Set) Nurse on 10/14/22 at 2:14 PM the Rehab Director had not been notified of the resident's weight loss and the resident will now be screened by Occupational Therapy. Per interview with a Registered Nurse (RN) on

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Facility ID: 475027

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		ND HUMAN SERVICES MEDICAID SERVICES			FO	ED: 10/31/20 RM APPROVI 10, 0938-03
ATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			TE SURVEY MPLETED C
		475027	B_ WING		1	0/14/2022
NAME OF PI	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE		
BENNING	TON HEALTH & REHAL	3		ACKBERRY LANE NINGTON, VT 05201		
		STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COR	RECTION	(×5)
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F 692	Continued From page	ae 51	F 692			
1 002		oximately 2:45 PM regarding				
0	the above concerns	s/he stated that the licensed				
	nursing assistants (LNAs) would find the ADL				
	interventions to incl	ude assistance needed for ent care Kardex. However,				
	while viewing the K	ardex the RN confirmed that				
	the care plan and K	ardex were not complete, and				
	the care needs were	e not identified on the resident	1 1		8	
	Kardex or care plan	. S/he also confirmed that the				
	LNA documentation	i was not complete.				
	3. Per record review	v Resident #18 was admitted dmission weight on 4/28/2022				
	was documented as states "Weigh ever	s 153.5 Lbs. A physician order y bath day/shower day every rsday (every Thursday) for				
	Health Monitoring A monitoring daily X 3	ND everyday shift for weight 3 days until 5/2/2022 23:59." sumented was 150.5Lbs. on				
	7/26/2022. The res	ident had experienced a three admission and had not been				
	monitored for addit	ional weight loss or basic				
		atus since the 7/26/2022				
	weight.					
	A care plan focus o	f "Resident may be				
	nutritionally at risk i	related to recent history of				
	aspiration pneumor	nia, dementia, bipolar disorder, n." Care plan goals include				
	"resident will consu	me >50% of all meals through				
	next review and ma	aintain weight of 154lbs +/- 5				1
	lbs, thru next review	w." In addition to the nutrition				
	care plan Resident	#18 also has a care plan				
	focus of "[name or	hitted] requires assistance with				
	toileting, personal	hygiene, walking, transferring, position in bed, and eating				
	related to: Anxiety,	Behavioral symptoms,				
	Change in Cognitiv	e Status, [Pneumonia [spelling			If continuation she	1

PRINTED: 10/31/2022 FORMAPPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPILE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON HEALTH & REHAB** BENNINGTON, VT 05201 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 692 Continued From page 52 F 692 corrected], Recent hospitalization." The documented interventions list eating but do not specify the amount of assistance from staff that the resident needs. Review of LNA documentation for the month of September 2022, revealed that out of 90 meals assistance and percentage of meal consumed were only documented on 24 occasions, and 6 of the 24 documented meals were refused. Review of the October 1-11th 2022 LNA documentation revealed that out of 33 meals assistance and consumption was only documented 4 times. Per interview with the RD on 10/14/2022 at 9:31 AM s/he confirmed that there had been no recent weights documented as ordered for Resident #18. S/he stated that s/he had learned from staff that the resident often refuses to allow weights but did not know if this was the issue and why it is not documented. Also, staff had not made her/him aware that the resident was at nutritionally at risk, or that there were concerns related to meal intake. During interview on 10/14/2022 at 3:30 PM a RN confirmed that the care plan did not identify the residents need for assistance for meals. S/He also confirmed that it was not reflected on the Kardex. 4. Per record review Resident #37 was readmitted to the facility on 8/25/22 after a hospital admission with the following diagnoses: Hemiplegia and Hemiparesis following cerebral infarction affecting left non dominant side, calculus of Gallbladder and Bile Duct without Cholecystitis without obstruction, Paroxysmal Atrial Fibrillation, Cerebral infarction unspecified, Major Depressive Disorder, Recurrent Moderate,

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INTER	SEOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			B NO. 0938-039	
TEMENT C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
		475027	B. WING		10/14/2022	
		4/502/		TREET ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER	\B	2	BLACKBERRY LANE ENNINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
F 692	Observation on 10 Resident #37 sittir with a breakfast tra- unsupervised. Res- time. Record review rew have a physician of Minimum Data Se reference date (Al revealed Supervis Area Assessment that they would pr Review of Reside	age 53 th, abnormal weight loss. 1/11/22 at 9:15 AM revealed or up on the edge of her/his bed ay in front of her/him sident declined interview at this ealed that resident #37 did not order for her/his diet. Review of t (MDS) with an assessment DR) of 8/17/22, Section G ion set up only. On the Care (CAA), the facility documented occeed with a nutrition care plan. Int #37's care plans revealed the have a dietary care plan in	F 692			
F 695 SS=D	Practical Nurse (L confirmed the MD documented they a dietary care plan confirmed that the in place and there place for resident Respiratory/Trach CFR(s): 483.25(i)	eostomy Care and Suctioning	F 695	Resident #23 oxygen concentrato	r	
	tracheostomy car The facility must of needs respiratory care and tracheal care, consistent v practice, the com	ratory care, including e and tracheal suctioning. ensure that a resident who care, including tracheostomy suctioning, is provided such with professional standards of prehensive person-centered idents' goals and preferences,		 has been cleaned. Oxygen tubing and humidification has been changed, dated and labeled. Resident #27 Floor under bed has cleaned. Oxygen tubing has changed, labeled and dated 	been	

Event ID: JB5X11

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION С 10/14/2022 R WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES п (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG Residents using oxygen have the F 695 potential to be affected by the deficient Continued From page 54 F 695 practice. and 483.65 of this subpart. This REQUIREMENT is not met as evidenced Education will be provided to the by: central supply clerk on replacing Based on observations, record review and staff oxygen tubing and humidification interview, the facility failed to provide oxygen weekly and labeling/dating items services including the safe handling, humidification, cleaning, storage, and dispensing when replaced. of oxygen for 2 residents (Resident #23 & Education will be provided to the Resident #27) of a sample of 4. Observations Maintenance staff regarding include: cleaning/preventative maintenance of oxygen concentrators. 1. Per record review and obsevation on 10/9/22 Resident #27 was positive for Covid-19 and actively receiving supplemental oxygen through Audits will be conducted to ensure an oxygen concentrator. The oxygen tubing on oxygen tubing and humidification the concentrator did not have a label to indicate has been changed per policy the last time it was changed. The humidifier bottle and oxygen concentrators are clean on the oxygen concentrator was also not labeled and in good condition Weekly X3 as to when it was last changed. Per inspection of then Monthly X3. the concentrator, it was noted to be sticky on the top with a layer of dust on the flat surfaces. Per The results of the audits will be interview on 10/9/22 at 10 AM the unit LPN reported and reviewed at the QAPI (Licensed Practical Nurse) observed the Committee Meeting Monthly X4 concentrator and tubing and confirmed the further evaluation if indicated. concentrator needed to be cleaned and the tubing Oversight will be provided by the should be labeled. Administrator or designee. 2. Per record review and observation on 10/10/22 F695 POL accepted 11/7/22 SFreemon Rol IPML Resident #23 was positive for Covid-19 and actively receiving supplemental oxygen through an oxygen concentrator. The oxygen tubing was very long and coiled on the floor under the resident's bed, the floor in the resident room was sticky and there was an accumulation of dust under the bed. The oxygen tubing did not have a label to indicate the last time it was changed. Per interview on 10/10/22 at 1PM the unit LPN confirmed the floor was dirty and the tubing should be labeled. Facility ID: 475027

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CENTERS FOR MEDI	CARE & MEDICAID SERVICES				B NO. 0938-03
TATEMENT OF DEFICIENCIES			(X2) MULTIPLE CONSTRUCTION A, BUILDING		DATE SURVEY COMPLETED C
	475027	B. WING		11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	10/14/2022
NAME OF PROVIDER OR SU			ST	REET ADDRESS, CITY, STATE, ZIP CODE	
BENNINGTON HEALTH				BLACKBERRY LANE ENNINGTON, VT 05201	
(A4) ID (EACH	UMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH GORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
§483.35(a) The facility the appropu- provide nur- resident sa practicable well-being of resident as and conside diagnoses a accordance at §483.35(a) by sufficient types of pe- nursing car resident ca (i) Except v this section (ii) Other nu- limited to n §483.35(a) paragraph designate a nurse on e This REQU by: Based on facility faile serve as a Findings in Per intervie	 3.35(a)(1)(2) Sufficient Staff. must have sufficient nursing staff with iate competencies and skills sets to sing and related services to assure fety and attain or maintain the highest physical, mental, and psychosocial of each resident, as determined by sessments and individual plans of care aring the number, acuity and of the facility's resident population in a with the facility assessment required e). (1) The facility must provide services to any required any set of the following resonnel on a 24-hour basis to provide to all residents in accordance with re plans: when waived under paragraph (e) of , licensed nurses; and ursing personnel, including but not urse aides. (2) Except when waived under (e) of this section, the facility must a licensed nurse to serve as a charge ach tour of duty. UREMENT is not met as evidenced interviews and record review the d to designate a licensed nurse to charge nurse on each tour of duty. 	9	725	 F 725 The Center will provide qualified and appropriate staff supervisor of designated charge nurse to be responsible for supervising Residirelated activities. Education has been provided to Nursing staff on the Center staffiplan. Audits will be conducted on sufficient nursing staff to ensure designated charge nurse is in platweekly X3 then Monthly X3. The results of the audits will be reported and reviewed at the Q Committee Meeting Monthly X with further evaluation as indicated. Oversight provided the DON or designee. FJA5 POL accepted Whyles Stream of the stream of th	or lent ing a ace. API (4 by

		D HUMAN SERVICES			FORM OMB NO	: 10/31/2022 APPROVED . 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A, BUILDING	(X3) DATE SURVEY COMPLETED C			
		47502 7	B. WING	and the second	10/1	4/2022
NAME OF PF	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
BENNING	TON HEALTH & REHAB			BLACKBERRY LANE ENNINGTON, VT 05201	N	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	was a nursing superv the building s/he state Per interview with the 10/9/2022 at approxin agency nurse that ha facility and not emerg informed that the sur and asked if we could charge. S/he stated the and that s/he would the of Nursing Services the survey team was in the confirmed that there being in charge during During interview with at 8:45 PM s/he state the survey team was there was a nursing signature s/he responded "I do	acility, and s/he was taff. When asked if there isor or someone in charge in ed that s/he did not know. Unit 3 North LPN on mately 8:50 PM s/he was an s been assigned to the pency staff. S/he was vey team was in the building d speak to who was in hat there was an RN on call ext her/him and the Director o inform them that the he building. The LPN was no-one designated as ig the evening shift. the Unit 2 LPN on 10/9/2022 ed that s/he was an a nurse. When informed that in the building and asked if supervisor in the building on't know. I don't think so."	F 725			
	10/9/22 it was noted the exception of one (LPN) on one unit fo contract/agency nurs designation to indica assigned the respon During an interview the facility scheduler	te anyone having been sibility of charge nurse. on 10/11/22 at 11:00 AM with · it was confirmed that no one				
F 726 SS=L	had been in charge Competent Nursing	on 10/9/2022. Staff	F 726			

Facility ID: 475027

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ENTERSFOR	F HEALTH AN	MEDICAID SERVICES				OMB NO.	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A, BUILDING			ETED	
			1				4/2022
		475027	B. WING	-		1 1011	12022
AME OF PROVIDER	OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
				-	ACKBERRY LANE		
ENNINGTON HE	ALTH & REHAB			BEI	NNINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 726 Conti	nued From pag	e 57	F	726	F 726		
6403	25 Nureing Ser	vices			The covid outbreak has been	resolved	
The fit the approvide resided practic well-to resided and contract of the second and contract of the second at §4 \$483 license and second at §4 \$483 limited to reside the second assee \$483 The to destech need assee This by: Base inter the second assee the second asecond asecond asecond asecond asecond assee the	propriate complete nursing and the nursing and active physical, reing of each re- ant assessmen onsidering the oses of the fact dance with the 33.70(e). 35(a)(3) The fact dance with the 3.70(e). 35(a)(3) The fact active shaw kill sets necess s, as identified ssments, and data .35(a)(4) Provided the constraint of sident's needs. .35(c) Proficient facility must en monstrate com- niques necessaries sidentification ssments, and data REQUIREMENT ed on observative state facility views the facility of the state sta	e sufficient nursing staff with petencies and skills sets to related services to assure attain or maintain the highest mental, and psychosocial esident, as determined by ts and individual plans of care number, acuity and ility's resident population in facility assessment required acility must ensure that e the specific competencies sary to care for residents' through resident tescribed in the plan of care. ding care includes but is not , evaluating, planning and ent care plans and responding			 Resident #52 Midline was dicontinued on 10/29/22 without complication. Negative Press: Wound Therapy continues and All Residents have the poter be affected by this deficient practice. Education will be provided including contracted staff, or implementation of TBP, hat hygiene and proper use of protective equipment. Education will be provided Licensed staff regarding Net Pressure Wound Therapy and IV The Contracted staff training a competencies for Negative Pressure Wound Therapy and IV The Contracted staff training a competencies for Negative Pressure Wound Therapy at therapy will be provided be taking assignment Audits will be conducted or and competency completion X3 then Monthly X3. 	to staff, on the nd ersonal to egative erapy. nd wind IV efore	

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DEPART	MENT OF HEALTH AN	D HUMAN SERVICES			OMB NO. (0938-0391
the second s		MEDICAID SERVICES	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU COMPLE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A, BUILDING			TED
					C 10/14	/2022
		475027	B, WING	IREET ADDRESS, CITY, STATE, ZIP CODE	10/14	ALOLL
NAME OF PR	ROVIDER OR SUPPLIER			BLACKBERRY LANE		
BENNING	TON HEALTH & REHAB			ENNINGTON, VT 05201	CTION	(X.5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPT DEFICIENCY)	DULD BE	COMPLETION DATE
F 726	care to residents bas medical care needs. The lack of staff train infection prevention residents in immedia death related to expo include: 1. During observatio approximately 9:15 I Assistant (LNA) assi observed entering th	ed on their individual ning and competency in and control placed the ate jeopardy of harm and/or osure to COVID-19. Findings on on 10/9/2022 at PM a Licensed Nursing igned to 3 South was ne room of a COVID-19	F 726	The results of the audits w reported and reviewed at the Committee Meeting Mont further evaluation if indicat Oversight will be provided DON or Designee. F726 Poc accepted 11/7	he QAPI hly X4 with ated. I by the	pri (pnu
	positive resident (ro gown or gloves. A si Transmission Based followed when enter donning of a gown a residents in room #3 LNA stated "I don't k sign on the door tha Personal Protective confirmed that s/he entering the room. T	om #316) without applying a gn on the door indicated that I Precautions should be ing the room to include the and gloves. When asked if the B16 were Covid positive the know." When directed to the t indicated the use of Equipment (PPE), the LNA should have used PPE when The LNA was asked if anyone shown her/him how and				
	10/11/2022 at appro been assigned to th outbreak. They all o received any trainin assignment nor had	a 3 agency LNAs on eximately 9:30 AM they had e facility due to the Covid 19 confirmed that they had not g prior to beginning their I the facility assessed them for her use of PPE and hand				
	staff educator confi	10/13/2022 at 10:46 AM the rmed that the facility had not ency staff with training related			continuation sheet Pa	

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON HEALTH & REHAB** BENNINGTON, VT 05201 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG F 726 F 726 Continued From page 59 to infection control such as proper use of PPE nor were they assessed by the facility for the skills necessary to prevent the spread of COVID-19 prior to their assignment. Review of a list provided by the facility of emergency response staff, there were 15 emergency response staff which included 7 nurses and 8 LNAs scheduled during the current Covid outbreak. Of the 15 emergency responders the there was no evidence that they received training or were assessed for competency related to proper use of PPE and other infection control practices prior to assuming a resident assignment. 3. On 10/12/2022 at 12:00 PM a LNA who was observed entering and exiting a room while wearing the following PPE: a plastic uniform covering gown, gloves, N95 mask and eye protection. They identified themself as agency staff and admitted to not knowing when to wear PPE or how to dispose of it. Per interview with the RN (registered nurse) Staff Educator and the RN Infection Control Preventionist on 10/11/22 at 10:30 AM agency/contract staff were not evaluated or trained prior to assuming an assignment to ensure their competencies and skills to care for the facility's resident population during the current Covid-19 outbreak. Per the Infection Preventionist "aside from getting them computer access we don't even know who they are". Per the Staff Educator who had been working on the unit and was relieved by one agency staff nurse, "I reviewed the medication room location, door codes, personal protection equipment location, I did not review any competencies". If continuation sheet Page 60 of 125

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Event ID: JB5X11

Facility ID: 475027

DEPART		D HUMAN SERVICES			PRINTED: 10/31/2022 FORM APPROVED OMB NO: 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475027	B. WING		10/14/2022
NAME OF PR	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE LACKBERRY LANE	
BENNING	TON HEALTH & REHAB			NNINGTON, 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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 726	Continued From page	e 60	F 726		
	interview with the Sta clarified that when nu through a staffing aging the facility that all cor- the staffing agency. A facility documentation competencies for agin facility contacted the evidence of staff self indicating training pro- 4. Review of the Res- nursing assignment revealed that Reside (Intravenous) for anti- to a diagnosis of an in- Review of the reside Administration Reco- had an order for a w- promotes vacuum- a to her/his left thigh re- acquired stage 4 pro- surgically debrided. Interview on 10/10/2 Rapid Response nu received any training	ency/contract staff, the staffing agency and obtained evaluations and check lists ovided by the staffing agency ident Roster Matrix and the sheet for the second floor, int #52 had a midline IV biotic administration related infected wound. Ints TAR (Treatment rd) revealed that the resident ound vac (a treatment that ssisted closure of a wound) elated to a community essure ulcer that was 2 at 10:05 AM with the LPN rse who stated she had not o or competencies specific to ation administration of the			
	MAR (Medication Ar revealed the followin Midline, change with dressing changes of	#52's 10/1/2022 - 10/31/22 dministration Record) ng orders: "Biopatch on n weekly and prn [as needed] ne time a day every 7 day(s) tart date of 10/01/2022 - this			
FORM CMS-25	for IV Care" with a s 67(02-99) Previous Versions Ob		5X11 Fac	cility ID: 475027	continuation sheet Page 61 of 12

PRINTED: 10/31/2022 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION C 10/14/2022 B WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES 1D (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 726 Continued From page 61 F 726 order was signed off as being done on 10/8/22; "Ertapenem Sodium Solution Reconstituted 1 GM [gram] Use 1 gram intravenously one time a day for Infected Wound for 28 Days SASH [saline antibiotic saline heparin] FLUSH via MIDLINE" with a start date of 10/01/2022 - this order was signed off as being done every day from 10/1/22 -10/13/22; "Heparin Lock Flush Solution 10 UNIT/ML [milliliter] (Heparin Lock Flush) Use 3 ml [milliliter] intravenously two times a day for SASH technique for 28 Days after administration of saline" with a start date of 10/01/2022 - this order was signed off every day from 10/1/22 - 10/13/22 at 1000 hours and every evening from 10/1/22 -10/5/22 and 10/7/22 - 10/8/22, and 10/10/22 -10/12/22 at 2100 hours; "IV: Change Midline Needless Connector one time a day every 7 day(s) for IV Care weekly" with a start date of 10/1/2022 at 0900 hour - this order was signed off on 10/8/22 (Monday, 10/1/22 was not signed as being completed); "Normal Saline Flush Solution Use 10 ml Intravenously one time a day for SASH/SAS [saline antibiotic saline] technique after med administration" with a start date of 10/01/2022 at 1000 hour - this order was signed off every day from 10/1/22 - 10/13/22; "Normal Saline Flush Solution Use 10 ml Intravenously one time a day for SASH/SAS technique prior to med administration" with a start date of 10/01/2022 - this order was signed off every day at 0900 hours from 10/1/22 - 10/13/22. Review of Resident #52's 10/1/2022 - 10/31/2022 TAR revealed the following orders: "Negative Pressure Wound Therapy To LLE SET Unit to 125 mmhg [millimeter of mercury] specify CONTINUOUSLY Cleanse with (NSS[Normal Sterile Saline]/Wound Cleanser/other) Place black foam into wound. Apply skin prep to intact If continuation sheet Page 62 of 125 Facility ID: 475027 Event ID: JB5X11 FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 10/31/2022 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG F 726 Continued From page 62 F 726 skin around the wound Cover with occlusive dsg [dressing] and secure tubing per manufacturer guide as needed for Surgically Debrided Stage IV [4] PU [pressure ulcer] if NWPT [Negative Wound Pressure Therapy] needs to be turned off for any care, tests/procedures (Bathing, MRI, etc), or for transport; remove dsg entirely, cleanse wound (NSS/Skinintegrity [sic]) and apply hydrogel gauze and secure with ABD [abdominal pad]" with a start date of 09/30/2022 at 1711 hours - this order was indicated as completed on 10/11/22. "Negative Pressure Wound Therapy To LLE SET Unit to 125 mmhg [millimeter of mercury] specify CONTINUOUSLY Cleanse with (NSS[Normal Sterile Saline]/Wound Cleanser/other) Place black foam into wound. Apply skin prep to intact skin around the wound Cover with occlusive dsg and secure tubing per manufacturer guide every day shift every Mon, Wed, Fri for Debrided Stage IV PU prior to admission" - with a start date of 10/03/2022 at 0700 - this order was indicated as completed on Monday 10/3/22 and Wednesday 10/5/22. There was no documentation to represent the the order was implemented/completed on 10/7/22, 10/10/22 or 10/12/22 Interview on 10/14/22 at 10:30 AM with the Infection Control Preventionist (ICP) regarding when and how nurses receive training and competencies to ensure residents are receiving the correct care and treatment of midline IV's and wound vacs. The ICP stated she/he could not find any competencies or policy and procedures regarding trainings for nurses specific to these specialty services. The ICP agreed that nurses are not typically trained to provide care of these specialties unless there was a need in the

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Event ID: JB5X11

Facility ID: 475027

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DEPART	VENT OF HEALTH AN	D HUMAN SERVICES				0. 0938-0391
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	1			E SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE COM A. BUILDING			NPLETED
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NAME OF PR	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CO	DDE	
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F 726			F 726			
F 727 SS=F	insertion and mainter catheters. Designate only train demonstrate comper maintenance of peri intravascular catheter	tence for the insertion and pheral and central ers." ;, Full Time DON	F 727	F 727		
L	l	Event ID: IB:	Extra Eacilit	v ID: 475027	If continualion shee	l Page 64 of 125

Facility ID: 475027

		AEDICAID SERVICES	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER: 475027		IDENTIFICATION NUMBER:	A, BUILDING		C	
		B, WING			/14/2022	
		4,002,	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
AME OF PF	OVIDER OR SUPPLIER		28	LACKBERRY LANE		
ENNING	ON HEALTH & REHAB		BE	NNINGTON, VT 05201		1. ¹
	CUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
(X4) ID PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	BE		DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	140	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	_	
F 727	paragraph (e) or (f) o must use the service least 8 consecutive h §483.35(b)(2) Excep paragraph (e) or (f) o must designate a reg director of nursing or §483.35(b)(3) The di as a charge nurse or average daily occup. This REQUIREMEN by: Based on interview failed to use the serv at least 8 consecutive week. Findings inclu During a review of th facility for actual hou noted that all the nu 24 hours were Licen there were no Regis during the timefram one having been de charge nurse there licensure (RN's) we assessment of resis 19 outbreak being e Nursing assessment information about a psychological, socio	d nurse t when waived under if this section, the facility s of a registered nurse for at nours a day, 7 days a week. t when waived under of this section, the facility gistered nurse to serve as the in a full time basis. irrector of nursing may serve hay when the facility has an ancy of 60 or fewer residents. T is not met as evidenced and record review the facility vices of a registered nurse for ve hours a day, 7 days a ide: the schedule provided by the urs worked on 10/9/22 it was reses who worked during the ised Practical Nurses (LPN's), stered Nurses (RN's) working e reviewed. In addition to no isignated to function as a were no nurses who by re able to perform an dents during the active Covid experienced by the facility. t is the gathering of resident's physiological, ological, and spiritual status by	F 727	The RN staffing coverage w reviewed with the staffing scheduler to ensure there is 8 consecutive hours a day for days a week. Education will be provided RN's and scheduler regardin 8 hours of consecutive RN coverage 7 days a week. Audits will be conducted o daily schedule to ensure the requirement is met. Weekly then Monthly X3. The results of the audits wi ported and reviewed at the Committee Meeting Month with further evaluation if n Oversight will be provided the DON or designee. FJAJ POL accepted Uhthz	at least or 7 to the og the f the y X3 II be re- QAPI ly X4 eeded. by	nan Ri IP
	assessments are CI	ed Nurse. Accurate rucial to recognizing critical ent's status to report to the				el Page 65 o

NTERS	FOR MEDICARE 8	ND HUMAN SERVICES			MB NO, 0938-03 (3) DATE SURVEY
ATEMENI OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING		C	
			5 10 10 10		10/14/2022
		475027	B. WING		10/14/2022
ME OF PR	OVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
				BLACKBERRY LANE	
INNING	ON HEALTH & REHA	B	BI	ENNINGTON, VT 05201	(X5)
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F 727	Continued From pa	ae 65	F 727		
1 (2)		resident's care needs are met			
	in a timely fashion.	The facility staffing	1		
	coordinator confirmed the accuracy of the schedule and that there were no RN's working			N	
	during the 24 hours	of 10/9/22.			
F 756	Drug Regimen Rev	iew, Report Irregular, Act On	F 756	F 756	
SS=D	CFR(s): 483.45(c)(Resident #27 Lipid Profile ordere	be
	A State States and			11/3/22. Oxycodone PRN order	
	§483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a			reviewed with physician 11/3/22	0
	licensed pharmacis			Pharmacy consultant re-	
				commendations were reviewed	to
	§483.45(c)(2) This of the resident's m	review must include a review edical chart.		ensure physicians have address recommendations.	ed
	§483.45(c)(4) The	pharmacist must report any		Education will be provided to	
	irregularities to the	attending physician and the		Licensed Nurses on Pharmacy	
	facility's medical di	rector and director of nursing, must be acted upon.		recommendations, Medication	
	(i) Irregularities inc	clude, but are not limited to, any		Regimen Review Policy 9.1.	
	drug that meets the	e criteria set forth in paragraph		Audits will be conducted of	
	(d) of this section f	or an unnecessary drug.		Pharmacy Recommendations to	0
	(II) Any irregularitie	es noted by the pharmacist must be documented on a		ensure completion, Weekly X3	3 then
	separate, written r	eport that is sent to the		Monthly X3.	
	attending physicia	n and the facility's medical		The results of the audits will b	e re-
	director and direct	or of nursing and lists, at a		ported and reviewed at the QA	AP1
	minimum, the resid	dent's name, the relevant drug, the pharmacist identified.		Committee Meeting Monthly	X4
	(iii) The attending	physician must document in the		with further evaluation as indi	icated.
	resident's medical	record that the identified		Oversight will be provided by	/ the
	irregularity has be	en reviewed and what, if any,		DON or designee.	
	be no change in th	ken to address it. If there is to le medication, the attending locument his or her rationale in		F756 POL accepted 11/7/22 ST	Freeman PW r
	the resident's med	locument ins or nor renement in			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A: BUILDING С 10/14/2022 B, WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON HEALTH & REHAB BENNINGTON, VT 05201** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 1D (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 756 F 756 Continued From page 66 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to ensure the pharmacist performs a Medication Regimen Review (MRR) reporting any irregularities to the attending physician and the facility's medical director and director of nursing, and that these reports are acted upon. Findings include: Per record review on 9/1/22 following the monthly MRR (a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) of Resident #27's medication regimen the pharmacist made the following recommendations: 1. Currently receiving Atorvastatin for dyslipidemia (a cholesterol lowering medication for elevated cholesterol levels). Unable to locate recent serum lipid profile in chart recommended 3 months after start then annually thereafter. Please consider ordering. 2. Currently receiving Oxycodone PRN (a narcotic pain reliever taken as needed) without a stop date. Please evaluate duration of therapy. Consider add a stop date of 14 days, if appropriate.

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING .__ AND PLAN OF CORRECTION C 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON HEALTH & REHAB** BENNINGTON, VT 05201 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) The results of these audits will be F 757 F 757 Continued From page 68 reported and reviewed at the QAPI facility failed to ensure one applicable resident Committee Meeting X4 Months (Resident #40) was free from unnecessary drugs. will further evaluation as indicated. Unnecessary drugs include medications Oversight will be provided by the administered in excessive doses. Findings DON or Designee. include: F757 POL accepted 11/1/22 SFreemen PN pm Per record review, Resident #40 was administered Lispro insulin in excessive doses. This resident had two different sliding scale insulin orders; one to be used if s/he was eating, and one to be used if s/he wasn't eating. Each of the Lispro sliding scale orders in the Electronic Medical Record system (EMR) indicate they are to be administered at the same times of day, except for an 0300 time for administration on the sliding scale for use when s/he would typically not be eating a meal or significant snack. There is also an order in the EMR which is signed by the nurses each shift which reads, "2 different sliding scales based on whether she is having a meal/significant snack or not. Every shift for type 1 DM, be careful to read both scales!" The times the orders appear in the EMR for administration are 0900, 1300, 1800, 2100, and 0300 only on the sliding scale as specified above. Insulin orders were effective as of 07/16/2022 and read as follows: 1) Insulin: Lispro Solution 100 unit/ml: Inject as per sliding scale: if 76 - 100 = 3 units with meals or significant HS Snack including popcorn; 101 -175 = 4 units with meals or significant HS Snack including popcorn; 176 - 225 = 5 units with meals or significant HS Snack including popcorn; 226 -275 = 6 units with meals or significant HS Snack including popcorn; 276 - 325 = 7 units with meals or significant HS Snack including popcorn; 326 -375 = 8 units with meals or significant HS Snack including popcorn; 376+ = 9 units with meals or

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A_BUILDING AND PLAN OF CORRECTION С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON HEALTH & REHAB** BENNINGTON, VT 05201 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 1D (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 757 Continued From page 69 F 757 significant HS Snack including popcorn, subcutaneously after meals and at bedtime for Diabetes AC Chem Sticks, ** If Not Eating a meal refer to other (this is the exact wording of the order) 2) Insulin: Lispro Solution 100 unit/ml: Inject as per sliding scale: if 76 - 100 = 0 If Not eating a meal or significant Snack; 101 - 175 = 0 If Not eating a meal or significant Snack; 176 - 225 = 0 If Not eating a meal or significant Snack; 226 -275 = 1 unit If Not eating a meal or significant Snack; 276 - 325 = 2 units If Not eating a meal or significant Snack; 326 - 999 = 3 units If Not eating a meal or significant Snack, subcutaneously five times a day if not eating a meal or significant snack. On the days and times, the insulin was given from both scales at the same time, it is unclear which dose resident #40 should have received. This is due to missing meal intake documentation in the Activities of Daily Living task section of the medical record, but it is clear s/he received both doses erroneously. There was documentation of 100 percent meal intake on 09/13/22 at noon, which resulted in the resident receiving one extra unit of Lispro at that time, Lispro insulin administration errors were made on the following dates, at the specified times, and the total units (u) administered include the number of units given from each scale combined: 09/04/22 at 2100, 7 u were administered, without food 1u would have been the correct dose. 09/08/22 at 2100, 7u were administered, without food 1u would have been the correct dose. 09/09/22 at 0900, 11u were administered, without food 3u would have been the correct dose. 09/13/22 at 1300, 7u were administered, without

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Event ID: J85X11

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PRINTED: 10/31/2022 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION C 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG F 757 Continued From page 70 E 757 food 1u would have been the correct dose. 10/04/22 at 0800 12u were administered, without food 3u would have been the correct dose. 10/08/22 at 0900, 11u were administered, without food 3u would have been the correct dose. 10/12/22 at 1300 9u were administered, without food 2u would have been the correct dose. On 10/14/2022 at 11:45 AM, a Registered Nurse confirmed the medication errors. At 2:45 PM the DNS confirmed there was missing meal documentation which made it unclear as to which dose of Lispro the resident should have received. This resident has a diagnosis of Diabetes and End Stage Renal Disease which requires dialysis. S/he was transferred to the Emergency Room on October 03, 2022, due to hypoglycemia. This was not a date where Lispro insulin had been given in excess, but it is an example of the fragile condition of this resident. Physician documentation in the medical record on October 06, 2022, includes the following statement, " ...60-year-old [gender omitted] with a history of diabetes, ... hyperglycemia (high blood sugar levels), ..., and hypoglycemia (low blood sugar levels) who presented to the ED (emergency department) after being found to have hypoglycemia. [S/he] has had multiple events in the past of unresponsiveness and low blood sugar. S/he does have Type 1 DM (diabetes mellitus)." F 761 F 761 Label/Store Drugs and Biologicals F 761 The facilities 3rd Floor room labeled CFR(s): 483.45(g)(h)(1)(2) SS=F clean utility room with a key pad §483.45(g) Labeling of Drugs and Biologicals entry has been relabeled to identify Drugs and biologicals used in the facility must be medication storage and the lock has labeled in accordance with currently accepted been changed to key entry for professional principles, and include the authorized personnel.

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Facility ID: 475027

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			(VA) DATE PURKEY
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A, BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		475027	B. WING		10/14/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
			2	BLACKBERRY LANE	
BENNING	TON HEALTH & REHAB		в	ENNINGTON, VT 05201	
04010	SUMMARY ST	TATEMENT OF DEFICIENCIES	ai	PROVIDER'S PLAN OF CORRECTION	COMPLETIO
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	-
F 761	Continued From pag		F 761	The 2nd floor clean utility roon been cleaned with stored medic	ation
	appropriate accesso instructions, and the	ry and cautionary expiration date when		and expired medication remove	ed.
	applicable.			Insulin Refrigerators have been	
	§483.45(h)(1) In acc	of Drugs and Biologicals ordance with State and ility must store all drugs and		Central supply room has been r viewed for expired medication expired medications being rem	s with
	biologicals in locked temperature controls personnel to have ac	compartments under proper a, and permit only authorized coess to the keys.		Omnicell access has been re- All licensed staff have been p access and a process is in pla- new staff access prior to start	rovided ce for
	locked, permanently storage of controlled the Comprehensive Control Act of 1976 a abuse, except when package drug distrib quantity stored is min be readily detected. This REQUIREMEN by: Based on surveyor interview, the facility labeling and storage Findings include: 1. On the facility's th nursing station is a r with a key code pad 10/11/22 at 8:45 am (LNA) was asked if s utility room. This LN "it's the same code f rooms, etc." All staff code were able to ac medications and bio	cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can T is not met as evidenced observation and staff failed to adhere to proper of drugs and biologicals. ird floor across from the oom labeled "clean utility" used to access the room. On , a licensed nurse assistant whe knew the code to the A knew the code and stated or all other utility rooms, linen with knowledge of the key ccess this room. The logicals were not stored in ts to be accessed by		 the floor All Residents have the potentia affected by this deficient prace Education will be provided the Licensed staff on Medication storage, dating, expiration and Management of controlled substances specific to single destruction and Omni- cell a process. Audits will be conducted on Medications, locked Med stor Omnicell Access, Insulin Refile locked and Central Supply are locked. Weekly X3 	al to be tice. d d dose ccess e, expire age, igerator

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES			FORM	: 10/31/2022 APPROVED .0938-0391
STATEMENT	S FOR MEDICARE & P OF DEFICIENCIES CORRECTION	AEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A, BUILDING	CONSTRUCTION	(X3) DATES COMPL	TED
		475027	B. WING		10/1	14/2022
	ICACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	2 B PREFIX	IREET ADDRESS, CITY, STATE, ZIP CODE BLACKBERRY LANE ENNINGTON, VT 05201 PROVIDER'S PLAN OF CORRECTIN (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	DBE	(X5) COMPLETION DATE
F 761	Continued From page authorized personne were found in the util unsecured tote filled on the floor, over the an unlocked medicat expired blood draw th cabinet, and there we inch syringes with net the sink. The counte debris and filth on the sheetrock wall. In the also multiple expired On 10/11/22, at 8:50 Nurse (LPN) confirm and confirmed LNA's but should not have are stored. On 10/17 Infection Prevention confirmed that the fil was clearly labeled door and on the faci as a "medication roo such items as one we clean utility room. S. vacutainers used for and only nurses sho On 10/12/22 at 2:17 asked if she was ab where medications? housekeeper knew room. S/he stated, and clean this area, weeks."	a 72 a 72 a only. The following items ity room: a large blue with prescription medications counter medications were in ion cabinet, multiple trays of ubes (vacutainers) were in a as a box of 26 gauge by ½ redles on the counter near rs were cluttered, there was a floor, and a hole in the a lab draw caddy there were vacutainers. D AM an Licensed Practical the expired vacutainers is have access to this room access where medications 1/22 at 4:45PM the facility ist (IP) was interviewed and bor was dirty, and the room 'Clean Utility'' outside the lity map but was being used om'' which did not contain vould expect to have in a the confirmed that the r blood draws were expired uld have access to this room. PM a housekeeper was le to enter the utility room	F 761	DEFICIENCY) then Monthly X3. The results of the audits will reported and reviewed at the Committee meeting Monthly further evaluation if indicate Oversight provided by the D designee. F161 PoL accepted III/1/22 S	l be QAPI V X4 with ed. DON or Freeman	1 pmi
	a strainer	Event ID: IB	5X11 F	Facility ID: 475027 If cor	itinualion sheet	Page 73 of 125

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Event ID: JB

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG F 761 Continued From page 73 F 761 will only be given to the nurses." 2. Observation on 10/9/22 at 8:56 PM, a LPN poured medication, which consisted of a Morphine Sulfate 15 mg tablet. The residents orders was for 7.5 mg. The nurse cut the pill in 1/2 with a pill cutter - she/he placed 1/2 of the pill in a medication administration cup and the other 1/2 of the pill in a medication cup which she/he placed inside a larger plastic cup (240 cc cup) and then placed the plastic cup inside the narcotics drawer in the medication cart. Review of the facility policy and procedure titled, "DISPOSAL OF MEDICATIONS AND MEDICATION-RELATED SUPPLIES", subtitle, "1E1: CONTROLLED MEDICATION DISPOSAL", subsection, "Policy, "Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations.", subsection, "Procedures", section A, "The director of nursing and the consultant pharmacist are responsible for the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications", section B, "When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of two licensed nurses, and the disposal is documented on the accountability record on the line representing that dose. The same process applies to the disposal of unused

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Event ID: JB5X11

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FORMAPPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO, 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION С 10/14/2022 475027 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON HEALTH & REHAB** BENNINGTON, VT 05201 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 761 Continued From page 74 F 761 tablets and unused portions of single dose ampules and doses of controlled substances wasted for any reason." Review on 10/9/22 of the narcotic book for this medication cart revealed that the 1/2 tablet of Morpine Sulfate had been wasted according to nursing standards are care that requires a controlled substance to be wasted in the presence of 2 licensed nurses. Interview on 10/10/22 at approximately 1:00 AM with the relieving/on coming 3 rd shift nurse, who confirmed she/he was a staff LPN. She/he confirmed that the LPN she/he relieved did not present any medications that required wasting. The oncoming staff LPN looked in the medication cart to check and see if perhaps the medication was left in the medication cart somewhere but there was nothing there to be wasted. It is unknown what happened to that 1/2 (7.5 mg) Morphine Sulfate tablet. The 3rd shift staff nurse also confirmed that the above noted refrigerator was an insulin refrigerator and it is supposed to be kept locked as it contains medications. She/he confirmed that upon her/his arrival to the unit for her/his shift that this refrigerator was unlocked. Interview with the above mentioned LPN at approximately 9:05 PM, confirmed that she/he did not lock the medication cart prior to leaving the medication cart and she/he walked away from the medication cart leaving the medication cart out of her/his sight. She/he stated that she/he does not usually leave the medication cart unlocked and unattended. When asked about the eye drops that were left on the top of the medication cart she/he confirmed that she/he had left them on the top of the cart but did not offer a reason why. If continuation sheet Page 75 of 125 Facility ID: 475027 EvenLID: J85X11 FORM CMS-2567(02-99) Previous Versions Obsolete

the second se	F DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			C	
		475027	B. WING			10/14/2022	
AME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP COL	DE		
		-		LACKBERRY LANE			
ENNING	TON HEALTH & REHA	AB	BEI	NNINGTON, VT 05201		-	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETI DATE	
F 761	Continued From pa	age 75	F 761				
	The LPN, confirme the "insulin refrige unlocked" when sh she/he doesn't eve the medication key	ed that the small refrigerator is rator" and that it is "always ne/he has been on shift and that en know if she/he has a key on y ring for the lock on this					
	refrigerator. Review of the facil	ity policy, titled, "MEDICATION					
	OF MEDICATION "Medications and securely, and prop recommendations	E FACILITY" "ID 1: STORAGE S", section "Policy", biological's are stored safely, berly, following manufacturer's or those of the supplier. The					
	nursing personnel members lawfully medications." Und "Procedures" B. " pharmacy personn authorized to adm	is accessible only to licensed , pharmacy personnel, or staff authorized to administer der subsection, titled, Only licensed nurses, nel, and ethos lawfully inister medications are allowed ions. Medication room, carts,					
	and medication su	pplies are locked and attended uthorized access."					
	locked Clean Utilit observed and note above, and below	approximately 9:18 PM, the y on the second floor was ed to consist of several cabinets the sink. A metal bar with a					
	pad lock was note cabinets and a lab medications were cupboards. Just i	d across 2 of the upper bel that specified back up contained within those nside the entry door on the					
	of Saline Nasal S Enoxaparin Sodiu of Nicotrol Inhaler	k basin that contained a bottle pray, Ventolin, a box of m Injection 40mg/0.4ml, a box 10 mg/cartridge (4 mg 1/2 full quart size see-through					
	plastic (ziplock) ba	ag containing a variety of bills or various shapes and					

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DEPARTN	IENT OF HEALTH AN	D HUMAN SERVICES			OMB NO, 0938-039
CONTRACTOR OF TAXABLE PROPERTY AND ADDRESS OF TAXABLE PROPERTY.		MEDICAID SERVICES	(X2) MULTIPLE CO	INSTRUCTION	(X3) DATE SURVEY
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		COMPLETED
		475007	B. WING		10/14/2022
		475027		ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PF	ROVIDER OR SUPPLIER			ACKBERRY LANE	
BENNING	ON HEALTH & REHAB		BEN	NINGTON, VT 05201	K
				PROVIDER'S PLAN OF CORRECT	TION (X5)
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE
F 761	Continued From page	e 76	F 761		
	sizes.				
		the second se			
	Interview on 10/9/22	at approximately 9:25 PM second floor regarding the			
	locked Clean Utility R	oom and the pink basin full			
	of medications, she/ł	he stated that these were			
	expired medications	that were there to be			
	destroyed.				
	Interview on 10/9/22	at approximately 9:30 PM			
	with a I NA regarding	the Clean Utility and if			
	she/he knew the cod	le to enter this room, she/he			
	provided the correct	code to access this Clean asked how she/he knew the			
	Utility room. When a	ver goes in this locked room,			
	she/he stated that sh	ne/he doesn't usually go in			
	the Clean Utility but	the access code to all locked			
	doors is the same th	roughout the facility.			
	4. Observation on 10	0/10/22 at 12:45 PM revealed			
	a Central Supply roc	om on the first floor. The door			
	to this supply room y	was fully opened and			
	accessible to unauth	norized individuals and there			
	were no staff present	it in the room at the time of is room contained the	1		
	facility's stock medic	cations/Over-The-Counters			
	(OTC's) and the liqu	id supplements. There were			
	26 individual contain	ners of Glucerna that were			
	expired on Sept 202	22.			
	Interview on 10/10/2	22 at 12:58 PM with the RN/			
	Infection Control Pre	eventionist (ICP) who			
	confirmed the above	e findings and stated the			
	Central Supply roon	n needs to be kept locked to ed individual access. The ICP			
	prevent unauthorize	there were 26 individual			
	servings of Glucern	a that were expired on Sept			
	2022.				
				ity ID: 475027 If co	ontinuation sheet Page 77 of 1

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PRINTED: 10/31/2022 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON HEALTH & REHAB **BENNINGTON, VT 05201** PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION 1D SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 761 F 761 Continued From page 77 5. Interview on 10/10/22 at approximately 4:15 PM with a second floor, [temporary agency] Licensed Practical Nurse (LPN) regarding access to emergency medications and access to a pixus type device revealed that she/he did not have access to this medication system. She/he stated that none of the Emergency Response staff have access to the pixus type system. She/he explained that she/he would need to find someone in the building that actually has access in order to get medications out of this system. When asked if there was ever a time she/he needed to get med's from this system and there was no one in the building to get the medications for patient needs - she/he confirmed that this has happened. When asked for further details and who the resident was - she/he stated it was a couple weeks ago, it was for a pain medication and there were only travelers in the building. She/he stated that the resident was a male and she/he did not remember his name. She/he said that the resident was angry because he couldn't get his pain addressed so he left the facility Against Medical Advice (AMA). Interview with a second [temporary agency] Registered Nurse (RN) confirmed that she/he also did not have access to the pixus type medication system. When asked what she/he would do if there was no one in the building who could gain access to this system in the building at a time of need, she/he stated she/he would start looking for phone numbers to find someone to call. When asked if she/he received any orientation to this facility specific to emergency numbers and a phone tree for who to call for certain situations/needs she/he stated nothing like that was provided. Interview on 10/11/22 at approximately 11:30 AM If continuation sheet Page 78 of 125

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PRINTED: 10/31/2022 FORMAPPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON HEALTH & REHAB BENNINGTON, VT 05201 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG F 761 Continued From page 78 F 761 with the Market President and the Regional Nurse Consultant regarding access to Emergency Medications in the pixus type system, specific to access rights to travelers and the Emergency Response nurses. The Regional Nurse Consultant stated that she/he does not give access to travelers or the Emergency Response nurses only to staff nurses. When asked how these medications are accessed for residents who need them when there is not a staff nurse in the building, she/he explained that there is always a nurse available to access these medications and phone numbers are available to call someone with access in an emergent situation. 6. Observation on 10/12/22 at approximately 10:30 AM on the second floor revealed the Nurse Practice Educator (NPE)/RN (Registered Nurse) who was working at the medication cart and providing medications to residents. She/he was observed leaving the medication cart with a cup of liquid and a small cup of pills, she/he entered a resident room, leaving the medication cart in the unlocked position. Interview with the above mentioned RN at approximately 8:40 AM, confirmed that she/he did not lock the medication cart prior to leaving the medication cart and the medication cart was out of her/his line of sight. F 812 F 812 Food Procurement, Store/Prepare/Serve-Sanitary F 812 No Residents were negatively affected SS=F CFR(s): 483.60(i)(1)(2) by the alleged deficient practice. §483.60(i) Food safety requirements. The facility must -§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, If continuation sheet Page 79 of 125

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Event ID: JB5X11

Facility ID: 475027

AEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES		(22)	B NO. 0938-039 DATE SURVEY
NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		UNSTRUCTOR	COMPLETED
				С
	475027	B. WING		10/14/2022
OR SUPPLIER		STR	REET ADDRESS, CITY, STATE, ZIP CODE	
			-	
LTH & REHAB	l l	BE		
EACH DEFICIENC	2Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
r local authori s may include ocal producers cal laws or reg s provision do es from using ns, subject to o rowing and fo is provision dr onsuming foo 50(i)(2) - Store food in accord ards for food s EQUIREMEN	ties. food items obtained directly is subject to applicable State gulations. lies not prohibit or prevent produce grown in facility compliance with applicable od-handling practices. bes not preclude residents ds not procured by the facility. e, prepare, distribute and dance with professional ervice safety. IT is not met as evidenced	F 812	affected by the deficient practice. Identified areas that require cleaning have been cleaned. Food storage areas identified have been cleaned with appropriate food storage. Maintenance Director ha addressed the pest control issue a out- side pest control vendor is routinely used. Education will be provided to the dietary staff on kitchen sanitation	f s ind
nined that the nd beverage s erving in acco ards for food s oservation on y team did a w kitchen with th ntionist), the f ved: e scoop was i e of the scoop box of "Instar ved in an ope hat was labele ined food proc the commercial	facility failed to ensure safe storing, preparing, distribution, rdance with professional service safety. 10/9/22 at 11:53 PM the valkthrough of the facility's the ICP (Infection Control following issues were inside the ice machine with the exposed to the ice. It Food Thickener'' was in plastic bag and set inside a d by the manufacturer as the duct.		 Maintenance Director related to Management. Audits will be conducted on kitchen sanitation, food storage, and pest management Weekly X the Monthly X3. The results of the audits will be reported and reviewed in the Q. Committee Meeting Monthly X with further evaluation if indicated. Oversight will be provided by the Administrator of designee. 	API 4 or
	OR SUPPLIER ALTH & REHAB SUMMARY S (EACH DEFICIENC REGULATORY OR aued From pag or local authoris s may include ocal producers cal laws or reg is provision do es from using in ns, subject to o rowing and for is provision do consuming foo 60(i)(2) - Store food in accord ards for food s REQUIREMEN d on Observation mined that the and beverage s erving in accord ards for food s bservation on y team did a w kitchen with th entionist), the f ved: the scoop was i le of the scoop box of "Instar ved in an ope nat was labele ined food prod he commercia bs and debris	IDENTIFICATION NUMBER: IDENTIFICATION IDENTIFICATION NUMBER: SUMMARY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: IDENTIFYING	ENCIES TTON (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE C A, BUILDING, 475027 B, WING OR SUPPLIER 2 B ALTH & REHAB BE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG nued From page 79 or local authorities. F 812 or local authorities. F 812 support of codi tems obtained directly ocal producers, subject to applicable storal ordowers, subject to applicable is provision does not prohibit or prevent es from using produce grown in facility. F 812 60(i)(2) - Store, prepare, distribute and food in accordance with professional ards for food service safety. REQUIREMENT is not met as evidenced d on Observation and interview, it was mined that the facility failed to ensure safe and beverage storing, preparing, distribution, erving in accordance with professional ards for food service safety. Execution on 10/9/22 at 11:53 PM the y team did a walkthrough of the facility's kitchen with the ICP (Infection Control entionist), the following issues were ved: Exe scoop was inside the ice machine with the ice of the scoop exposed to the ice. box of "Instant Food Thickener" was rved in an open plastic bag and set inside a hat was labeled by the manufacturer as the ine food product. be commercial blender was dirty with bes and debris around the blender motor and	ME_DICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) ADDRESS (X1) PROVIDERSUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) ALTH & REHAB STREET ADDRESS, CITY, STATE, 2IP CODE 2 BLACKBERRY LANE SUMMARY STATEMENT OF DEFICIENCIES 0 PROVIDERS PLAN OF CORRECTION REQUIDENCENCY ONLY TO ESCIL 0 PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 0 PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 0 PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 0 PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCY TAG PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCY TAG PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCY TAG PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCY TAG PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 0 PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCY TAG ALL RESIDENT ADDRESS, CITY, STATE, 2IP CODE SUMMARY STATEMENT OF DEFICIENCY TAG ALL RESIDENT ADDRESS, CITY, STATE, 2IP CODE SUMMARY STATEMENT OF DEFICIENCY

Event ID: JB5X11

Facility ID: 475027

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	MENT OF HEALTH AN	D HUMAN SERVICES			FOR OMB N	D: 10/31/2022 M APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A, BUILDING		COM	E SURVEY PLETED
	у.	475027	B. WING		10	C /14/2022
NAME OF P	ROVIDER OR SUPPLIER	1		ET ADDRESS, CITY, STATE, ZIP CODE ACKBERRY LANE		
BENNING	TON HEALTH & REHAB			NINGTON, VT 05201 PROVIDER'S PLAN OF COI	RECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 812	the pitcher. e.) An air conditioner windows across from puree machine and v food prep were store noted to have a thick front grill where the of conditioner and into thick and sticky subs dust, and insects. In was a spray can of n without the cover, an non-stick spray was product, also withour f.) An opened box o the counter next to the three, 4-inch binders labeled "Lunch", and g.) On a 3-tiered util and middle rack how plastic containers of of which 6 were ope h.) A commercial sil- table and was cover Upon removing the 1 mixer, it was noted to the mixing bowl, and where the mixing bowl, and where the mixing bowl spattered with dried mixer sat on. i.) A commercial can table and was noted substance on the bill bracket that holds the a thick black and ye with/containing what i.) A large refrigeral	blades are located inside r was observed in one of the the table where the mixer, various other equipment for d. The air conditioner was and sticky substance on the cool air comes out of the the environment. Within this tance was noted some hair, front of the air conditioner on-stick spray that was to beside that spray can of a second can of the same ta cap. f cornstarch was noted on the air conditioner, in front of a second can of the same ta cap. f cornstarch was noted the top sed bulk spices of which 18 spices were on the top rack, in to the environment. zed mixer was noted on a ed with a black trash bag. black trash bag to view the to be dirty - the wire guard, d underneath the mixer above wil would sit were all material, as was the table the n opener was attached to a to have a thick sticky red ade of the can opener and the the removable can opener had llow sticky substance t appeared to be a hair. tor was observed and upon a full container/pitcher with a	F 812	y ID: 475027	If continuation shee	t Page 81 of 125

	MENT OF HEALTH AN	D HUMAN SERVICES			FORM OMB NO	: 10/31/2022 APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATES COMPL	LETED
		475027	B, WING		10/*	14/2022
	ROVIDER OR SUPPLIER		2 BL	ET ADDRESS, CITY, STATE, ZIP CODE ACKBERRY LANE ININGTON, VT 05201		
(X4) ID PREFIX TAG	IGACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	DBE 1	(X5) COMPLETION DATE
F 812	light-yellow liquid insi the tag was written "C second container/pitot tangerine-colored liquitag or markings to re- expiration/use by dat k.) A steam table with noted to be full of hot l.) A sideboard attacc visibly dirty with a wh m.) In the corner of the entrance/exit door was was covered with var Upon closer inspection ants, spiders, flies (la other insects and dirt was a large mousefr n.) In front of the abi- was a substance that variations of brown, substance appeared sitting in an area that color that extended f mouse trap and enco- brown object. The of This was shown to the that she/he did not k was as "I'm not a bio not mouse [dropping o.) The grout in the black and crusty over p.) A large commen- stacked square and there were moisture layers of stacked co q.) A second large of revealed stacked so	de, revealed a tag and upon Drange - Use by 9/16". A full cher was noted with a uid inside and there was no veal the contents or an e on the container. In 3 separate sections were dirty water. The d to the steam table was ite greasy substance. The kitchen, behind the 2nd as a sticky mouse trap that rious sizes of black spots. On these black spots were arge and small), and various t. To the left of the sticky trap t was dark brown with yellow, black, and red. This wet and was noted to be t was wet with a clear grayish from the sticky trap and ompassed this unidentified biget could not be identified. The ICP person who stated now what this brown object hologist but I can tell you that's gs] or rat [droppings]". kitchen was noted to be tround plastic containers and Awater droplets between the ntainers. commercial utility rack quare metal containers and Awater droplets between the	F 812			Page 82 of 125

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FORMAPPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A, BUILDING AND PLAN OF CORRECTION С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 812 F 812 Continued From page 82 r.) A steam machine was noted to be wet inside on the sides and top of the machine. s.) Under the oven/stove was a thick sticky and greasy substance black in color, that extended under a utility rack and a light-yellow substance was noted dripping down the front of the stove on the oven door and was pooling on the lip at the bottom of the stove/oven. t.) The inside of the oven was noted to have a large thick pool of black and red gel like substance on the inside base of the oven. At the time of the kitchen walk-through, the ICP was present for the entire walk-through, and as issues presented, they were shown and confirmed by the ICP person. The ICP confirmed that it is the expectation that the dietary staff clean the kitchen prior to leaving for the night, especially when managing an identified issue with rodents. (see F925) Observation on 10/10/22 at 8:45 AM in the kitchen revealed a staff member in the dish room with her/his mask under her/his chin. Interview with this staff person regarding her/his role in the kitchen, she/he pulled her/his mask up under her/his nose. The Food Service Director (FSD) and her/his supervisor were present at the time of this observation and interview with the staff, and when ask if the staff member was wearing her/his mask/PPE (Personal Protective Equipment) correctly, the Food Service Director Supervisor confirmed she/he was not and she/he spoke to the staff member telling her/him that she/he needed to wear her/his mask correctly. The staff member at that time pulled her/his mask up over her/his nose demonstrating appropriate PPE use at that time. A walk-through of the kitchen with the Food Service Director and her/his supervisor, If continuation sheet Page 83 of 125

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FORMAPPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A-BUILDING AND PLAN OF CORRECTION Ċ 10/14/2022 475027 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON HEALTH & REHAB** BENNINGTON, VT 05201 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 812 Continued From page 83 F 812 the above findings from 10/9/22 were discussed and confirmed by the FSD's supervisor. She/he stated that she/he had already cleaned the equipment, and the air conditioner and would be scraped along with the grease under the stove and extending areas. She/he stated that a pressure washer would be the best way to keep the floors clean, but the facility does not allow for pressure washers in their kitchens. During this walk-through the utility racks where the square metal pans, and the round and square plastic containers were observed were found to again/still be wet inside between the containers and pans. The FSD Supervisor confirmed that this is not sanitary and is a breeding ground for organisms. The mouse traps were observed and the FSD and FSD Supervisor confirmed that there are mice in the facility. When asked about whether they had seen any rats, they confirmed that they had in the past and plastic tubs were purchased to store and protect food from rodents, Several plastic tub lids were noted to have large holes that appeared to have teeth marks. When asked about these holes and quetionable teeth marks both staff responded that the rats had chewed through the covers and some of the heavy-duty storage tubs. A mouse trap was observed in the dry storage area under a commercial utility rack along with a square black box. When asked what this box was, the FSD Supervisor picked it up and looked it over and said she/he didn't really know but said she/he would get the maintenance man to help figure it out. At approximately 9:15 AM a maintenance staff person came to the dry storage area and explained that the black box was a "bait box" for rats and confirmed that the facility has had an issue with rats and a professional company had been involved but now the maintenance If continuation sheet Page 84 of 125 Facility ID: 475027 Event ID: JB5X11

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		D HUMAN SERVICES			PRINTED: 10/31/20 FORM APPROV OMB NO. 0938-03	/ED
STATEMENT	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		475027	8. WING		10/14/2022	_
	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	2 E	REET ADDRESS, CITY, STATE, ZIP CODE BLACKBERRY LANE ENNINGTON, VT 05201 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLET	ION
F 812	traps. A walk-through supervisor continued item/substance that h before was observed asked what the item of her/his supervisor co- supervisor stated the washed every night. picked up the unidem said she/he thought i sausage". Resident Records - lo CFR(s): 483.20(f)(5) §483.20(f)(5) Resider (i) A facility may not r resident-identifiable i accordance with a co agrees not to use or except to the extent to do so. §483.70(i) Medical ro §483.70(i)(1) In accor professional standar must maintain medic that are- (i) Complete; (ii) Accurately docum (iii) Readily accessib (iv) Systematically o	onsible for checking the a with the FSD and her/his and the unidentified brown had been noted the evening in the same place. When was, neither the FSD or uld identify the item but the kitchen floor is swept and The FSD put on a glove and tified item/substance and twas "a piece of petrified dentifiable Information 483.70(i)(1)-(5) ht-identifiable information. elease information that is to an agent only in outract under which the agent disclose the information the facility itself is permitted ecords. redance with accepted ds and practices, the facility ial records on each resident hented; le; and rganized cility must keep confidential ined in the resident's records,	F 812	F 842 Resident #54 no longer resides the facility. All Residents have the potentia affected by the deficient practice Education will be provided to Licensed and LNA staff on charting and documentation Pot OPS402 to include E-Interact. Education will be provided to Licensed staff on evaluation af fall specific to Neurological Evaluation. Audits will be conducted to en completion of LNA document Interact completion and Neur Evaluation completion Week	l to be ce. blicy fter a nsure tation, ological	
		m or storage method of the		III ID 475007 If continu	ation sheet Page 85 of	125

Facility ID: 475027

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PRINTED: 10/31/2022 **FORM APPROVED** DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING ... C 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 BENNINGTON HEALTH & REHAB (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG Monthly X3. F 842 Continued From page 85 F 842 records, except when release is-The results of the audits will be (i) To the individual, or their resident reported and reviewed at the QAPI representative where permitted by applicable law, Committee Meeting Monthly X4 (ii) Required by Law; further evaluation if indicated. (iii) For treatment, payment, or health care Oversight will be provided by the operations, as permitted by and in compliance DON or designee. with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, F842 POL accepted 11/2 SFreeman Rolpm neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164 512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-(i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain-(i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and If continuation sheet Page 86 of 125 Facility ID: 475027 Event ID: JB5X11 FORM CMS-2567(02-99) Previous Versions Obsolete

ENTER	S FOR MEDICARE & I	ID HUMAN SERVICES				O. 0938-039
ATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G		E SURVEY IPLETED
		475027	B. WING		10)/14/2022
		475027		STREET ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER			2 BLACKBERRY LANE BENNINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST HE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR	HOULD BE	(X5) COMPLETION DATE
F 842	(vi) Laboratory, radio	e 86 Ilogy and other diagnostic equired under §483.50. T is not met as evidenced	F 8	42		
×	by: Based on review of i to maintain complete records in accordance	information, the facility failed and accurate medical we with accepted professional ents (#14, #18, #5, #54, #40)			4	
	Nursing Assistant (Ll needs provided such mobility, toileting, as percentage of meal of of September reveal completed on only 8 there was no docum evening shift through LNA documentation had multiple spaces Day shift documenta completed on 3 shift was no documentation	consumed during the month ed documentation was day shifts, 11 night shifts and entation completed on nout the entire month. for October 1 - October 14th that were not completed. tion for all care areas was s between 10/1- 10/14, there on completed on evening documentation of all care				
	2. Per record review documentation of ca bathing, dressing, be assistance needed a consumed during the revealed documenta 10 day shifts, 11 nig documentation comp throughout the entire	Resident #18 LNA re needs provided such as ed mobility, toileting, and percentage of meal e month of September ttion was completed on only ht shifts and there was no pleted on evening shift				

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PRINTED: 10/31/2022 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING ____ AND PLAN OF CORRECTION С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON HEALTH & REHAB** BENNINGTON, VT 05201 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 842 Continued From page 87 F 842 had multiple spaces that were not completed. Day shift documentation for all care areas was completed on 2 shifts between 10/1- 10/14, there was no documentation completed on evening shift, and night shift documentation of all care areas was only 4 shifts. 3. Per record review Resident #5's LNA documentation of care needs provided such as bathing, dressing, bed mobility, toileting, assistance needed, and percentage of meal consumed from October 1 - October 14th has multiple spaces that were not completed. Day shift documentation for all care areas was completed on 3 shifts between 10/1-10/14, there was no documentation completed on evening shift, and night shift documentation of all care areas was only 5 shifts. During interview on 10/14/2022 at 2:30 PM with the Infection Control Preventionist [ICP] regarding the lack of LNA documentation, particularly the evening shift, while reviewing the LNA documentation flow sheet the ICP confirmed that the LNAs had failed to document care provided. S/he stated that all staff including agency LNAs, and emergency staff have access to the electronic health record, and they can and should be documenting the care provided. 4. Upon record review on 10/14/22 Resident #40 did not have accurate meal documentation recorded in the Activities of Daily Living (ADL) task section of the electronic medical record (EMR). This information is part of a complete medical record and in this case was also needed because Resident #40 had insulin orders that required dosing based on meal intake. In reviewing the ADL records for September and If continuation sheet Page 88 of 125

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Event ID: JB5X11

Facility ID: 475027

		AND HUMAN SERVICES & MEDICAID SERVICES			OMBNO	
EMENTO	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE COM A, BUILDING		(X3) DATE COMP	LETED
		475027	B. WING			, 14/2022
ME OF PE	ROVIDER OR SUPPLIER		STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
				CKBERRY LANE		
NNING	TON HEALTH & REH	а́В	BENI	NINGTON, VT 05201		
X4) ID PREFIX TAG	(EACH DEELCIE	Y STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
F 842	Continued From p	age 88	F 842			
, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		here are multiple blank boxes				
	for meal recording	. There was other required ADL				
3	information missin	ig in the EMR such as:			ļ	
	dressing, transfers	s, bed mobility, personal				
	hvaiene, etc. On t	his same date at 2:45 PM an				~
	Registered Nurse	(RN) confirmed there was				
	missing ADL docu	mentation to include meal				
	documentation red	quired for complete medical				
	records and insuli	n administration.	3			
	E Upon record re	view for Resident #40 on				
	10/14/22 it was fo	ound that this resident had been				
	transferred to the	hospital on October 03, 2022				
	due to hypoglycer	nia. This information was found				
	on a hospital discl	harge record from				
1	Southwestern Ver	mont Hospital which was				
	scanned into the I	EMR. No medical assessment	5			
	was entered into t	he EMR progress notes on that				
	date indicating an	acute change in this resident's				
	condition requiring	g a hospital transfer, and no				
	medical assessme	ent or other entry was found in				
	the EMR progress	s notes of the resident's return				
	from the hospital.	There was an Interact hospital Id scanned into the medical				
	transfer form foun	orm used for hospital transfers				
	record. This is a li	such as pertinent medical				6
	history acute cha	nges in a resident's medical				
	status that require	es transfer to the hospital at that				
	time and the most	t recent vital signs, etc. The				1
	Interact hospital to	ransfer form was not filled out				
	with accurate or o	organized information. The date				
	of transfer was er	tered as 09/01/22, but it also				
	included medical	information dated 10/03/22. The				
	form could not be	utilized to gather information for				
	either October or	September reliably as it was				1
	filled out inaccura	tely.				
	Upon interview or	10/14/22 at 2:45 PM with the I Nurse Consultant and an RN				

PRINTED: 10/31/2022 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION С 10/14/2022 **B. WING** 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON HEALTH & REHAB BENNINGTON, VT 05201 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 1D (EACH CORRECTIVE ACTION SHOULD BE (X4) 1D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 842 Continued From page 89 F 842 acknowledged the 2 different dates of information on the same Interact form. The only other information found in the EMR related to this transfer was a scanned in fax form to the provider stating, "Resident had unresponsive episode accompanied by low BS (blood sugar level). We would like a PRN (as needed) Glucagon (Glucagon is a medication used to increase blood sugar levels quickly) IM shot (an injection into the muscle) when she is unable to take the gel po (by mouth)." 6. Record review reveals that resident #54 was admitted to the facility on 08/09/22 and died at the facility on 09/05/22 due to acute chronic hypoxic respiratory failure secondary to aspiration pneumonitis and advanced dementia per a practitioner note (09/06/22). This resident had the following diagnoses: Dementia, Delirium, Depression, A-fib, Benign Prostatic Hyperplasia, glaucoma, Hypothyroidism and Dysphagia. This resident contracted COVID-19 virus said to be resolved on 07/14/22 per a practitioner note (08/12/22). This was a resident transferred from another nursing home facility. Further review of the medical record indicates that this resident had a fall on 08/14/22. A nurse note reveals "LNA (Licensed Nurse Assistant) reported hearing loud bang while in the room across the hall from [name omitted], when [s/he] entered the room saw pt. laying on the floor next to his bed, this nurse entered the room after being notified by LNA and saw pt. laying on [her/his] right side next to [her/his] bed, small abrasion noted to top of head, neuro vital signs WNL, VSS, no indication of fx or other injury, floor mats in place, bed in lowest position, assisted back to bed with Hoyer lift and two assist". There

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Event ID: JB5X11

Facility ID: 475027

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TATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION (X3) D/	NO 0938-039 ATE SURVEY OMPLE FED
		475027	B. WING		C 10/14/2022
	ROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE BLACKBERRY LANE BENNINGTON, VT 05201	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 842	SBAR assessment" of however further docu neurological checks/v in the medical record patient with a head in to top of head). The N resident can change ensuring that "neuro for at least four hours the first 24 hours afte nursing assessment. Algorithm) https://rn-j It was confirmed by to Consultant on 10/12/ was no documentation	al "change in condition complete for this resident, imentation related to vital signs could not be found as one would expect for a njury (noted above-abrasion Neurological status of a abruptly and suddenly, so checks" usually every hour s, then every eight hours for a fall is an important (Post-Fall Care Nursing journal.com)	F 842		
F 880 SS≖L	Infection Prevention CFR(s): 483.80(a)(1) §483.80 Infection Co The facility must esta infection prevention a designed to provide a comfortable environm development and tra diseases and infection §483.80(a) Infection program. The facility must esta	(2)(4)(e)(f) ntrol ablish and maintain an and control program a safe, sanitary and ment and to help prevent the nsmission of communicable ons. prevention and control ablish an infection prevention (IPCP) that must include, at	F 880	 F 880 Sanitizer dispensers have been changed and are filled with sanitizer product. Linen was removed from the floor. Resident #52 Mid Line has been discontinued without complications Laundry and trash bins are covered. Shower rooms have been cleaned and broken tiles replaced. Mattress and linen removed. 	

Facility ID: 475027

PRINTED: 10/31/2022 FORM APPROVED

DELYGUT	NENT OF HEALTING	ND HUMAN SERVICES			OMB NO. 0938-03
		MEDICAID SERVICES	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING		COMPLETED
		475027	B. WING		10/14/2022
			STF	REET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PI	ROVIDER OR SUPPLIER	24	2 8	LACKBERRY LANE	
BENNING	TON HEALTH & REHAE	3	BE	NNINGTON, VT 05201	
(X4) ID PREFIX TAG	JEACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMILETIO
F 880	and communicable staff, volunteers, vis providing services u arrangement based conducted accordin accepted national s	ing, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessment g to §483.70(e) and following tandards;	F 880	Clean Utility rooms have been cleaned and storage organized Medication storage signage ha been added and the key numbe lock has been removed and re- with a key lock entry with onl authorized staff use. 2nd Floor kitchenette and dir	s r pad placed y
	procedures for the p but are not limited t (i) A system of surv possible communic infections before th persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tr to be followed to pr (iv)When and how resident; including (A) The type and d depending upon th involved, and (B) A requirement least restrictive pos circumstances. (v) The circumstan must prohibit empli- disease or infected contact will transm (vi)The hand hygie by staff involved in \$483,80(a)(4) A sy	eillance designed to identify able diseases or ey can spread to other ty; iom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the esible for the resident under the ces under which the facility poyees with a communicable if skin lesions from direct ents or their food, if direct		 has been cleaned. Steam tab other equipment has been cleaned. Food stored in has been cleaned. Food stored in has been discarded. Mouse traps have been replac pest bait boxes. Laundry room/carts have beer and disinfected. Mattress from Room #205 haremoved and discarded. All identified kitchen issues been corrected. All Residents have the poten affected by the deficient prace 	le and all aned. It have Iproperly ed with a cleaned s been have tial to be

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PRINTED: 10/31/2022 FORMAPPROVED

	S EOR MEDICARE &	ND HUMAN SERVICES				0938-039
ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	ONSTRUCTION	(X3) DATE S COMPL	
) PLAN OF	CORRECTION	DENTIFICATION NOTICE.	A, DUILDING		C	;
		475027	B. WING		10/1	4/2022
			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
AME OF P	ROVIDER OR SUPPLIER		28	LACKBERRY LANE		
BENNINGTON HEALTH & REHAB			BE	NNINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETM DATE
F 880	Continued From par corrective actions to §483.80(e) Linens. Personnel must hau transport linens so infection. §483.80(f) Annual r The facility will con IPCP and update th This REQUIREMED by: Based on observal documentation, the maintain an infection program designed comfortable enviro development and t other communicab deficient practices control measures so and containment le residents who resid immediate jeopard At the time that imm 10/11/2022, review residents who had since the beginnin began on 10/1/202 positive residents During the outbrear residents who died Findings include: 1. Per record revie facility staff to be up	ge 92 aken by the facility. ndle, store, process, and as to prevent the spread of	F 880	Education will be provide the implementation of TB Hygiene and proper use of Protective Equipment inc donning and doffing. Education will be provide staff regarding kitchen sa procedures. Education will be provide Laundry/Housekeeping s Environmental cleaning p Audits will be conducted TBP, Hand Hygiene, and and doffing of PPE. Wee then Monthly X3. Audits will be conducted Environmental cleanline kitchen sanitation/cleanline kitchen sanitation/cleanline disinfection Weekly X3 Monthly X3. The results of the audits reported and reviewed a Committee Meeting Mo further evaluation is ind Oversight will be provide Administrator or design F860 POC concepted ut-	P, Hand f Personal luding ed to dietary nitation ed to the taff on procedures. to include donning kly X3 l of ss, ness and and then will be t the QAPI nthly X4 icated. led by the ee.	ren Pil J F

	MENT OF HEALTH AN		FORM APPROVED OMB NO. 0938-0391			
and the second se	S FOR MEDICARE & M	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING		COMPLETED	
		475027	B_WING		C 10/14/2022	
				TREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PI	ROVIDER OR SOFFEIER		2	BLACKBERRY LANE		
BENNING	BENNINGTON HEALTH & REHAB			ENNINGTON, VT 05201		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	Department Report w that the admitting dia respiratory failure, sh of Resident #7's Ver states that the primar COVID-19 infection. 2. Per observations in the third floor (Unit 3 10/9/2022 at 8:45 PM Practical Nurse (LPN preparing medication eye protection. When residents on the Sou COVID-19 s/he state there were 11 confirr residents in her/his c 3. On 10/9/2022 at a Licensed Nursing As South was observed positive resident's ro required personal pro gown or gloves. A sig Transmission Based followed when enter positive resident to ir and gloves. When as #316 were Covid pos know." When directe indicated the use or s/he should have use room. The LNA was facility had shown he PPE s/he stated "No	of the hospital Emergency ritten on 10/5/2022 revealed gnoses were acute hypoxic ock, and COVID-19. Review mont Certificate of Death y cause of death was nade during the initial tour of North and South) on 1, the 3 South Licensed I) was observed in the hall is for administration without asked how many of the th unit were positive for d, "I think three" However, ned COVID-19 positive are. pproximately 9:15 PM a sistant (LNA) assigned to 3 entering two COVID-19 om (#316) without the otective equipment (PPE), a gn on the door indicated that Precautions should be ng the room of a COVID-19 oclude the donning of a gown sked if the residents in room sitive the LNA stated "I don't d to the sign on the door that PPE, the LNA confirmed that ed PPE when entering the asked if anyone from the er/him how and when to don	F 880		5	
	On 10/9/2022 at app Director of Nursing (DNS) entered the facility.				

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Event ID: JB5X11

Facility ID: 475027

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		MEDICAID SERVICES	(X2) MULTIPLE CO	INSTRUCTION		E SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CO	C :
		475027	B. WING	w	1	0/14/2022
	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
			2 BL	ACKBERRY LANE		
BENNINGTON HEALTH & REHAB			BEN	NINGTON, VT 05201		1
(X4) ID PREFIX TAG	FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION. CROSS-REFERENCED TO THE # DEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE
F 880	Continued From page 94 When approached by this surveyor s/he stated that s/he had not been feeling well and that s/he was going to take a COVID test. When this surveyor returned the DNS stated that she was positive for COVID and that s/he was trying to contact the Executive Director. The DNS remained in the facility in her/his office. S/he was there when the surveyors exited the facility at approximately 1:00AM. On 10/9/2022 at approximately 9:45 PM the Infection Control Preventionist (ICP) was informed of the infection control concerns related to the use of PPE (personal protective equipment) and the potential spread of COVID-19 that had been identified. S/He was asked if it was the expectation that staff wear a face shield or goggles as PPE when on the unit the ICP stated "yes, it is." At approximately 10:15 s/he was seen		F 880	3		
	assigned to the 3rd observed exiting a r resident (room #323 and gloves that s/he room. The LNA wall contaminated gown COVID-19 positive care products. S/he into the resident's ro should have remove washed her hands s/he confirmed that 5. Review of the face	10:20 PM an agency LNA North and South Unit was from of a COVID-19 positive 3), without removing the gown a had been wearing in the ked down the hall with the and gloves from the room, to retrieve incontinence a then returned walking back boom. When asked if s/he ed the gown and gloves and when s/he exited the room s/he should have.				
	10/9/2022, revealed	provided by the ICP on d that 7 of the 12 residents floor (2 North) were				

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION C 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 880 F 880 | Continued From page 95 COVID-19 positive, and one additional resident was currently admitted to the hospital with COVID-19. Of the 19 residents on the 3rd floor North Hall, 12 of them were COVID-19 positive. On the 3rd floor South Hall there were 20 residents total with 11 that were COVID-19 positive. On 10/10/2022 at 9:34 AM during interview with the facility Executive Director s/he confirmed the above COVID-19 cases and provided documentation (the facility "Heat list" On 10/11/2022 the list was updated to reflect two new COVID-19 positive residents on 2nd floor Unit 2). When informed of the multiple concerns identified throughout the facility on 10/9/2022, s/he stated "we are in the middle of a COVID outbreak, and we have travelers and emergency staff working Things were getting better until this outbreak happened." 6. Per observation on 10/10/22 at 12:15 PM, a LNA was seen in a resident's room (#317) delivering a lunch tray to a COVID-19 positive resident without wearing the required gown and gloves. Upon leaving the room, s/he did not perform any hand sanitization. Signage was posted on the wall outside the room indicating that Transmission-Based Precautions (TBP) were to be followed and that required Personal Protective Equipment (PPE) was to be worn prior to entering the room. When asked why s/he failed to wear the required PPE or wash hands or perform any hand sanitizing, s/he stated, "I just didn't think about it, I'm agency." 7. The sanitizer mechanism located on the wall unit outside of room #311, on the left side of the North Hall, was empty and did not contain any If continuation sheet Page 96 of 125 Facility ID: 475027 Event ID: JB5X11 FORM CMS-2567(02-99) Previous Versions Obsolete

	MENT OF HEALTH AN					0: 10/31/2022 APPROVED 0: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING			LETED
		475027	B. WING	NI, was Prijawan	10/	C 14/2022
NAME OF PR	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP (ODE	
				ACKBERRY LANE		
BENNING	TON HEALTH & REHAB		BEI	NNINGTON, VT 05201	CORRECTION	(X.5)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	COMPLETION DATE
F 880	Continued From page hand cleaning produc	t, Room #312, a room	F 880			
	hand sanitizer, and th available to place soi the room, thus causir	autions, did not contain any ere was no receptacle led PPE in prior to exiting og staff to exit the room and the receptacle in the hall,	-			
	sanitizer and recepta housekeeping at the need replacing. 8 Observation on 10	cles were confirmed by time they were found to /10/22 at 12:30 PM revealed		54 		
	an LNA in the resider #212, wearing an N9 strap laying across th nose. At the time of was observed walkin	nt hallway outside of room 5 mask with the top elastic te top of mask on her/his his observation, the LNA g by the ICP, who NA and failed to correct		2		-
	regarding the observ confirmed that the LI PPE correctly, as the placed around her/hi	2 at 12:55 PM with the ICP ation noted above. The ICP NA was not wearing her/his a top elastic strap should be s head as per the mmendations for use.				
	10/11/2022 at 9:20A observed entering a room (#317) without protective equipmen shield. When s/he ex asked if the resident COVID-19 and if the	t (PPE) on, other than a face kited the room s/he was in that room was positive for resident was on precautions hould have put on a gown				
FORM CMS 25	67(02-99) Previous Versions Ob	solete Event ID:JB5	5X11 Fac	lily ID: 475027	If continuation sheet	Page 97 of 125

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A, BUILDING .__ AND PLAN OF CORRECTION С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 880 Continued From page 97 F 880 10. During observation on Unit 3 South on 10/11/22 at 11:00 AM a LNA was seen entering a room (#324) of two COVID-19 positive residents without a protective gown and gloves and set up a meal tray for the resident. Upon exit of the room this surveyor asked the LNA if the residents in the room were positive for COVID or if they no longer required use of PPE, the LNA confirmed that they were COVID-19 positive, and s/he should have had it on. 11. Per observation on 10/12/22 at 12:00 PM an LNA entered a resident room on a COVID-19 positive unit on the third floor to respond to a call light. The facility was amid a Covid 19 outbreak and following transmission-based precautions to include all staff wearing N-95 masks and eye covering. When entering a resident room designated as having residents with Covid-19 by a sign at the door the additional infection control measure included donning a disposable plastic gown to protect clothing and protect residents from cross contamination. The LNA approached the room already dressed in PPE to include plastic clothes covering gown, gloves, an N-95 mask and a face shield, upon entering the room the LNA handled the call bell to turn it off, put his/her hand on the resident's arm and exited the room without removing the PPE or sanitizing his/her hands. The LNA confirmed he/she was unsure of when to Donn or doff his/her PPE. 12. Per observation on 10/12/2022 at 12:10 PM a trash receptacle inside room #303 designated as having Covid-19 positive residents was observed to be overflowing with disposable PPE with soiled linens on the floor next to it. This practice increases non-infected residents' risk of exposure to COVID-19. The unit LPN confirmed used PPE If continuation sheet Page 98 of 125 Facility ID: 475027

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Event ID: JB5X11

PARTI	NENT OF HEALTHA	ND HUMAN SERVICES				0.0938-039
TEMENTO	S FOR MEDICARE 8 OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A BUILDING	(X3) DATE SURVEY COMPLETED C		
			B. WING			/14/2022
		475027		T ADDRESS, CITY, STATE, ZIP CODE		
ME OF PF	ROVIDER OR SUPPLIER			CKBERRY LANE		
	TON HEALTH & REHA	В		VINGTON, VT 05201		
	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5) COMPLETIC
(X4) ID PREFIX TAG	(CACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)		DATE
F 880	Continued From pa	ge 98	F 880			
	and linens did not b					
	13. Per observation	at 10/12/2022 12:15 PM on				
	the third floor in the	empty resident dining area 2				
	LNA's were observ	ed standing near the food a conversation without				
	service area having	eye protection, when				
	questioned both LN	A's confirmed they should be				
- I	wearing N-95's and	eve protection. On				
	10/12/2022 at appr	oximately 12:50 PM the				÷
	Regional Nurse Co	nsultant confirmed that the				
	staff should be wea when on the Unit.	ring masks and eye protection				Y
	when on the onit.					
	14. Observation or	10/12/22 at 1:34 PM an LNA				
	was observed com	ing out of resident room #213				1
	which housed a rea	sident who was COVID-19				ii.
	positive. The LNA	eaned out over the door by of dishes and attempted to				
	flag down a staff m	ember to come take the tray.				
	Another LNA came	e and took the tray without				
	gloves on and plac	ed the tray inside the tray cart.				
	She/he did not per	form hand hygiene and				
	immediately proce	eded to room #211, where ved going into this room and no				
	she/he was observ	performed before entering.				
	Room #211 does r	not house a COVID-19 positive				
	resident at the time	e of this observation. The				
	same LNA was ob	served coming out of room				
	#211 with a tray th	at contained dishes, paper				2
	towels were obser	ved as a barrier between the				
	tray and her/his ha	nds. She/he took the tray to d the tray inside the cart and				
	nroceeded to the k	itchenette entrance door where				
	she/he entered the	e lock code on the code pad,				
	opened the door to	o the kitchenette and entered.				
	She/he did not per	form hand hygiene between				
	putting the tray fro	m room #211 into the tray cart ock code on the kitchenette				
	Land entering the lo	ock code on the kitchenette				

		D HUMAN SERVICES				D: 10/31/20 MAPPROV D: 0938-03
ATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		SURVEY	
	Ϋ́α.	475027	B. WING	- to a second se		14/2022
AME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE		
BENNING	TON HEALTH & REHAB			ACKBERRY LANE NINGTON, VT 05201		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETI DATE
F 880	Continued From page door.	99	F 880			
	noted LNA, regarding practice of picking up positive room vs. the room. She/he said it was supposed to be stated that she/he ha training regarding inf	2 at 1:38 PM with this above g the differences in her/his b trays from a COVID-19 non-COVID-19 positive was not clear what she/he doing at that point. She/he id received some additional ection control practices, but it thirely clear what the process tray pick up.				
	noted putting a gowr #211 (not designated She/he was interview regarding her/his pra gown into a non-cow that the gowns and g that have signs on th room #211 had a sig didn't know. Room # indicating the room w 9:52 AM on 10/13/22 observed going into	40 AM a laundry person was a on and going into room d a covid positive room). wed on 10/13/22 at 9:42 AM ictice of wearing a disposable id room and she/he stated gloves are required in rooms be doors. When asked if n on the door and she/he #211 did not have a sign was a precaution room. At 2 this same laundry staff was a COVID-19 positive 3) with a few hangers of				2
	laundry and entered disposable gown or outside room #213 in the use of PPE. Inte who confirmed that s disposable gown an that is indicated by a precaution room. Th not see any sign - th laundry staff, as well inside the door on th	the room without a gloves. There was a sign ndicating the requirement for rview with the laundry staff she/he should be wearing a d gloves to enter any room a sign that the room is a ne laundry staff member did he sign was pointed out to the l as the orange sign that was ne left side of the wall to wear PPE, she/he stated		ά.		

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG F 880 Continued From page 100 F 880 that she/he "was used to the sign being a little higher" and that she/he did not see it. 16. Interview on 10/13/22 at 1:20 PM with the ICP regarding the training and competency of staff related to infection control and COVID-19 prevention, revealed that "Genesis employees" must do their annual mandatory educational training on the "Vital Learn Electronic System". The ICP can run reports for tracking and states "I do spot checks for extra training when we have unit managers." The ICP "keeps records of education but not always." If agency staff are hired, when they come through the door, the ICP reviews their agency packet to see what's needed. Per the ICP "We lag on this.". Audits are conducted in the housekeeping/laundry department on a weekly basis. Observations of meal service are conducted weekly to observe hand hygiene, gloving, and wearing proper personal protective equipment (PPE) during delivery of meal trays to COVID positive rooms and dietary staff serving behind the line. Observations are done in the kitchen monthly to observe preparation of food, and cleanliness of kitchen. The ICP states "audits have not been done in a while since we came back to Genesis [this occurred in July]" and no evidence related to the above was provided. On 10/14/22 at 09:21 AM a list of examples of training/audits (minus the mandatory annual education which another nurse educator works on) was given to the ICP. This list included items such as cleansing of equipment (glucometer, mechanical lift, wheelchairs, et.), hand hygiene, COVID education, reporting breaches of the integrity of equipment. There is no documented evidence of audits related to infection control. The

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: J85X11

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OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ C 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON HEALTH & REHAB BENNINGTON, VT 05201** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 880 F 880 Continued From page 101 ICPs response at 11:52 AM when asked for the above information regarding any audits/education was "No, I don't have any of this." Additional findings of non-compliance related to infection control that were identified during the survey include: 1. Observation in room #205, on 10/13/22 at 10:45 AM of Resident #52's midline IV was place in her/his left upper arm. A dressing was observed over the midline IV that was grayish in color and appeared dirty - the dressing was dated 9/29/22. Interview on 10/13/22 at 10:45 AM with the resident, who is A&Ox3 and stated that this dressing is the dressing that was put on at the hospital prior to her/his admission to this facility. This was reviewed with the nurse, who confirmed she/he was part of the emergency response team and was an LVN (Licensed Vocational Nurse). She/he confirmed that Resident #52's dressing appeared dirty, and she/he also confirmed the date on the dressing as being 9/29/22 and that this resident was admitted to this facility on 9/30/2022. 2 Observation on 10/9/22 at 8:40 PM of the second floor (Unit 2) revealed a long hallway with an open nurses station in the middle. The portion of hall to the left of the nurses station housed 12 residents, 7 of these residents were Covid-19 positive. One additional COVID-19 positive resident was currently admitted to the hospital. The portion of the hallway to the right of the nurses station was empty of residents. The hallway that was housing residents was observed to have a lot of debris on the floor, consisting of

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: JB5X11

Facility ID: 475027

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PRINTED: 10/31/2022 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING ___ С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE BENNINGTON, VT 05201 **BENNINGTON HEALTH & REHAB** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 880 Continued From page 102 F 880 gloves, clear plastic wrappers, small pieces of paper, and long pieces of thin blue plastic, as well as dirt/sand. To the right side of the resident's hallway were 2 uncovered bins, 1 contained what appeared to be dirty gloves, and the other appeared to be empty. Interview on 10/9/22 at 8:35 PM with an LNA, who stated one bin is for trash and the other bin she/he believed was for linens. She/he stated, "I do not know if they should be covered, this is only my third shift here and I don't know the policy for having the bins covered or uncovered." Interview on 10/9/22 at 8:50 PM with the nurse on duty who identified her/himself as an emergency response nurse, confirmed the hallway where resident rooms are located was littered with debris that consisted of gloves, pieces of blue plastic that she/he identified as pieces of the disposable gowns that are used to go into the rooms of residents who are on precautions due to a covid positive status, clear plastic wrappers, she/he identified as the packaging to protective eyewear, small pieces of paper and dirt. She/he stated that staff have not had time to clean on the unit and to her/his knowledge there are no housekeeping staff available. When asked about the uncovered bins in the resident's hallway, she/he stated they were for dirty linens and disposable items and thought they "probably should be covered and labeled," she/he did not know the facility policy regarding bins in the hallway. 3. Observation on 10/9/22 at 9:08 PM of the tub/shower/whirlpool room revealed a shower area that was separated from a second shower area and a whirlpool tub area. Upon entering the tub/shower/whirlpool room to the left is a shower If continuation sheet Page 103 of 125 Facility ID: 475027 Event ID: JB5X11 FORM CMS-2567(02-99) Previous Versions Obsolete

		D HUMAN SERVICES MEDICAID SERVICES			FOR OMB N	D: 10/31/2022 MAPPROVED D: 0938-0391
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	ROVIDER OR SUPPLIER		 2 BLA	T ADDRESS, CITY, STATE, ZIP CODE CKBERRY LANE VINGTON, VT 05201		
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F 880	many broken tiles, so most of the grout that tiles was gray, black, a washcloth that was at the right side of the washcloth appeared was hard/crusty and the right of the entrar first shower area (ref bariatric sized tub ch unfolded towel hangi shower chair. To the tub/shower/whirlpool shower area was a s revealed a PVC (poly bed with thick plastic was in disrepair. Th foam covered mattre piece of clear plastic mattress. Upon touc was noted to be mois pressure a clear liqui mattress. On the floo area was a gray plas secure residents in ti use of the whirlpool shower area and atop of the cove that had some piece material that resemb masks around and o Interview on 10/9/22 emergency response the shower room wa infection control issue s/he would leave a fit	o be dirty, the floor had ime missing pieces of tile, was between the remaining or yellow in color, there was draped over the shower bar a shower wall. The dirty, it was gray in color, it formed to the shower bar. To nee door, across from the erenced above) was a air and upon it was an ing off the left side of the left of the room, to the right of the first econd shower area that yvinyl chloride) pipe shower foam covered mattress that e headrest of the plastic ss revealed 3 slits and a tape that exposed the foam h of the foam mattress, it st and with a little applied id oozed out of the foam or of this second shower tic strap that is used to he tub chair for transport and tub. To the right of this was a covered plastic bin r was a neatly folded johnnie s of white plastic type bled drier sheets, and 2 face in top of the johnnie.	F 880			

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DEPART	NENT OF HEALTH A	ND HUMAN SERVICES			OMB N	MAPPROVED 0.0938-0391
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		475027	B, WING			/14/2022
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP COL 2 BLACKBERRY LANE 3 BENNINGTON, VT 05201	JE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		D PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPF DEFICIENCY)			(X5) COMPLETION DATE
PREFIX	JEACH DEFICIENCY MUST BE PRECEDED BY FULL		F 880			
	was not covered . a	II of 2x2 gauze squares and and 1 labeled APPLICATORS uue depressor sticks, that was				
	kitchenette and din can, dishes with for dirty shelves and in under a commercia between the kitche of the serving area doors, and the mic the doorway and fl thick black substan	10/9/22 at 9:30 of the 2nd floor ing area revealed a full trash od on trays, a refrigerator with uside doors, a large mouse trap al utility shelving unit, a rat trap nette wall and the refrigerator , dried food on counters, rowave. The bottom part of por into the kitchenette had a nee that was also present in the re wood floor at the doorway.				

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CI IA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING ___ С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON HEALTH & REHAB BENNINGTON, VT 05201** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION ID. SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 880 F 880 Continued From page 105 The 3 compartments in the steam table each had dirty water in them with what appeared to be food particles and debris. 6. Observation on 10/9/22 at 11:53 PM the survey team did a walkthrough of the facility's main kitchen with the ICP, the following issues were observed: a.) Ice scoop was inside the ice machine with the handle of the scoop exposed to the ice. b.) A box of "Instant Food Thickener" was observed in an open plastic bag and set inside a box that was labeled by the manufacturer as the contained food product. c.) The commercial blender was dirty with crumbs and debris around the blender motor and on the table the equipment was sitting on d.) The food puree machine pitcher was cracked all the way around the bottom of the container just above where the blades are located inside the pitcher e.) An air conditioner was observed in one of the windows across from the table where the mixer, puree machine and various other equipment for food prep were stored. The air conditioner was noted to have a thick and sticky substance on the front grill where the cool air comes out of the conditioner and into the environment. Within this thick and sticky substance was noted some hair, dust, and insects. In front of the air conditioner was a spray can of non-stick spray that was without the cover, and beside that spray can of non-stick spray was a second can of the same product, also without a cap. f.) An opened box of cornstarch was noted on the counter next to the air conditioner, in front of three, 4-inch binders - 1 labeled "Breakfast", 1 labeled "Lunch", and 1 labeled "Dinner" If continuation sheet Page 106 of 125 Facility ID: 475027 Event ID: JB5X11 FORM CMS-2567(02-99) Previous Versions Obsolele

PRINTED: 10/31/2022 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING С 10/14/2022 B. WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON HEALTH & REHAB** BENNINGTON, VT 05201 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 880 F 880 Continued From page 106 g.) On a 3-tiered utility rack, it was noted the top and middle rack housed 18 plastic containers of spices on the top rack of which 6 were open to the environment h.) A commercial sized mixer was noted on a table and was covered with a black trash bag. Upon removing the black trash bag to view the mixer, it was noted to be dirty - the wire guard, the mixing bowl, and underneath the mixer above where the mixing bowl would sit were all spattered with dried material, as was the table the mixer sat on, i.) A commercial can opener was attached to a table and was noted to have a thick sticky red substance on the blade of the can opener and the bracket that holds the removable can opener had a thick black and yellow sticky substance with what appeared to be hair. j.) A large refrigerator was observed and upon opening the doors, a full container/pitcher with a light-yellow liquid inside, revealed a tag and upon the tag was written "Orange - Use by 9/16". A full second container/pitcher was noted with a tangerine-colored liquid inside and there was no tag on the container. k.) A steam table with 3 separate sections were noted to be full of hot dirty water I.) A sideboard attached to the steam table was visibly dirty with a white greasy substance m.) In the corner of the kitchen, behind the 2nd entrance/exit door was a sticky mouse trap that was covered with various sizes of black spots. Upon closer inspection these black spots were ants, spiders, flies (large and small), and various other insects and dirt. To the left of the sticky trap was a large mousetrap. n.) In front of the above-mentioned sticky trap was a substance that was dark brown with variations of brown, yellow, black, and red. This

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		D HUMAN SERVICES				D: 10/31/2022 MAPPROVED O. 0938-0391
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F 880	Continued From page	e 108	F 880			
	kitchen revealed a st with her/his mask un with this staff person the kitchen, she/he p her/his nose. The Fo and her/his supervise this observation and when ask if the staff mask/PPE (Persona correctly, the Food S confirmed she/he wa the staff member tell needed to wear her/ member at that time her/his nose demon- at that time. A walk- the Food Service Dii the above findings fr and confirmed by the 8. Observation on 11 noted that a tray will napkins were placed control cart outside brought to the attent Preventionist (ICP) ICP confirmed the tr cart and stated that top of the infection of are considered a classical 9. On 10/11/22 at 08 floor unit, revealed station which is labor code pad. This sam	0/10/22 at 12:33 PM it was h dishes, utensils, and d on top of the infection of room 211. This was tion of the Infection Control on 10/10/22 at 1:32 PM. The ray atop the infection control nothing should be placed on control carts as these carts				
FORM CMS-25	such on the facility i 67(02-99) Previous Versions Of	map. This surveyor asked a	5X11 Fac		If continuation she	et Page 109 of

		D HUMAN SERVICES				FORM OMB NO	: 10/31/2022 APPROVED 0938-0391
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	475027				- Million - A. A. Communication - D		14/2022
	ROVIDER OR SUPPLIER			2 8	REET ADDRESS, CITY, STATE, ZIP CODE BLACKBERRY LANE ENNINGTON, VT 05201		
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F 880	code was. This LNA I stated, "it's the same and proceeded to let entrance, the small ro medication storage a Utility" room. It conta medications in a cabi medications on the fl with needles (box of cabinet, and other su filthy with debris on the sized area of sticky si confirmed that the floo did not "ever really no 10. Observation on 11 laundry department, the transport of soile to be unclean with va- such as used gloves products, a hair tie, a unrecognizable parti- lint, dust and debris is contains large bucket chemicals. Interview with a laundry attend appearance of the di- build up under the w Another observation and interview with th Preventionist (ICP) v afternoon on 10/11/2 confirmed that the lay wood pallet near the fifthy. The ICP confir	stant (LNA) what the door knew the door code and for all other utility rooms" two surveyors in. Upon bom appeared to be a rea rather than a "Clean ned over the counter net, a blue plastic tote full of bor, Lab supplies, syringes 26G x1/2" syringe) in a pplies. The utility room was he floor and a dark quarter ubstance. The LNA for was dirty, and that s/he eed anything in here". 0/11/22 at 01:27 PM of the contains laundry carts, for d linens. One cart was noted trious items of built-up debriss food particles, paper in meal ticket, and other cles. There were layers of under a wooden pallet that ts of washing machine v at the time of observation lant, confirmed the rty laundry cart and dirt/grime boden pallet.	F	880			

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		ND HUMAN SERVICES MEDICAID SERVICES				ED: 10/31/2022 MAPPROVED O. 0938-0391 E SURVEY
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON			IPLETED
AND PLAN OF	CORRECTION					C 0/14/2022
		475027	B. WING	ET ADDRESS, CITY, STATE, ZIP COD		5/14/2022
NAME OF PI	ROVIDER OR SUPPLIER			CKBERRY LANE		
BENNING	TON HEALTH & REHAE	3		NINGTON, VT 05201		
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F 880	Continued From pag	je 110	F 880			
	with a housekeeper dirty and s/he "does Utility" floor but has housekeeper reveal her/his cleaning res s/he "had never had cleans the floor to th that [s/he] should no medications but did 11. Observation of th room and Interview the ICP confirmed th the room was clean outside the door an being used as a "m contain such items in a clean utility roo ICP confirmed that cleaned in a while a	ervation and interview on 10/11/22 at 2:17PM a housekeeper confirmed that the floor was r and s/he "does usually wash the "clean ty" floor but has been out for two weeks". This sekeeper revealed that all of 3rd floor is his cleaning responsibility. S/he stated that e "had never had a nurse observe while [s/he] ons the floor to this room and was not aware [s/he] should not enter due to it containing dications but did know the code". Observation of the 3rd floor "Clean Utility" m and Interview on 10/11/22 at 4:45PM with ICP confirmed that the floor was dirty and that room was clearly labeled "Clean Utility" side the door and on the facility map but was ng used as a "medication room" which did not tain such items as one would expect to have clean utility room. For example, Linens. The confirmed that this room had not been aned in a while and that only nurses should		÷		
	2:30PM, Observation Genesis Nurse Corr was not being used indeed did not contr expect, and the floor 12. Observation on #205 at 10:58 AM, on the bed next to the been stripped of line and at the foot of the of approximately 2- significant wear to	afternoon of 10/12/22 at on and interview with a isultant confirmed the room I as a "Clean Utility" and ain linens as one would or was still dirty. 10/13/22 upon exiting room it was noted that the mattress the door in room #205 had eens leaving just the mattress ne mattress there was an area foot diameter that showed the fabric covering the a was where the manufacturer				

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ENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES			NO. 0938-039		
ATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C		
		475027	B. WING		10/14/2022		
AME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE			
				BLACKBERRY LANE			
BENNING	TON HEALTH & REHAB		В	ENNINGTON, VT 05201 PROVIDER'S PLAN OF CORRECTION			
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F 880	Continued From pag		F 880				
	company, mattress t unreadable informat	mattress the name of the type and various other ion - most of this was gone. The integrity of					
	the mattress is poor adequately. The nu at the same time col	and unable to be cleaned rse, who was exiting the room nfirmed the appearance of					
	was not usable and	e/he stated that the mattress needed to be replaced. This ittention of the Clinical Quality Market President on 10/13/22					
F 888	at approximately 11 COVID-19 Vaccinat	:15 AM. ion of Facility Staff	F 888				
SS=F	CFR(s): 483.80(i)(1) §483.80(i)	ion of facility staff. The facility		The 16 TLC contracted staff are no longer working at the facility.			
	must develop and in procedures to ensur	nplement policies and re that all staff are fully ID-19. For purposes of this		All Residents have the potential to b affected by this deficient practice.	ie		
	section, staff are co	nsidered fully vaccinated if it or more since they completed on series for COVID-19. The		Education will be provided to the Nursing Administration team	ion		
	completion of a prin COVID-19 is define	nary vaccination series for d here as the administration of ne, or the administration of all		on the Universal Covid 19 vaccinati policy.			
	required doses of a	multi-dose vaccine.		Audits will be conducted on new hires to ensure they have a completed primary vaccination			
	or resident contact, must apply to the fo provide any care, tr	rdless of clinical responsibility the policies and procedures Ilowing facility staff, who eatment, or other services for	2	series. Weekly X3 then Monthly X3.			
	the facility and/or its(i) Facility employe(ii) Licensed practil	s residents: es; ioners;		The results of the audits will be reported and reviewed at the QAPI Committee Meeting			
	(iv) Individuals who	es, and volunteers; and o provide care, treatment, or ne facility and/or its residents,		Monthly X4 further evaluation if indicated. Oversight will be			

		MEDICAID SERVICES		E CONSTRUCTION	(XI) DAT	0. 0938-03 E SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		C	
		475027	8, WING	1(10/14/2022	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	
i w une or i				2 BLACKBERRY LANE		
BENNING	TON HEALTH & REHAB			BENNINGTON, VT 05201		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	. ID	PROVIDER'S PLAN OF CORF	ECTION	(XS) COMPLETK
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		DATE
F 888			F 888	provided by the Administ designee.	rator or	
	under contract or by other arrangement.					
	section do not apply	blicies and procedures of this to the following facility staff:		FBBD POC accepted 11/1/2	z Streemank	allpnu
	telemedicine service	ely provide telehealth or s outside of the facility setting				
	residents and other s	any direct contact with staff specified in paragraph (i)				
	(1) of this section; an	a e support services for the				1
	facility that are perfor	rmed exclusively outside of				ŧ
		d who do not have any direct				
	contact with resident paragraph (i)(1) of th	s and other staff specified in is section.				
		blicies and procedures must				
	(i) A process for ens	n, the following components: uring all staff specified in				
		is section (except for those				
		ng requests for, or who have otions to the vaccination				
	requirements of this	section, or those staff for				
		ccination must be temporarily		1		
		ended by the CDC, due to and considerations) have				
		um, a single-dose COVID-19				
	vaccine, or the first d					
		r a multi-dose COVID-19				
	vaccine prior to staff treatment, or other se	providing any care, ervices for the facility and/or				
	its residents;					
	(iii) A process for en	suring the implementation of				
	additional precaution	is, intended to mitigate the ead of COVID-19, for all staff				
		cinated for COVID-19;				
	(iv) A process for trac	cking and securely				
	documenting the CO all staff specified in p	VID-19 vaccination status of				

	MENT OF HEALTH AN				200	FORMAPPROVED
CENTER	S FOR MEDICARE & M	MEDICAID SERVICES			1	IB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED C
		475027	8. WING		10/14/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 BLACKBERRY LANE		
BENNING	TON HEALTH & REHAB			BENNINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 888	any staff who have ob as recommended by fi (vi) A process by whice exemption from the st requirements based of (vii) A process for tradi- documenting informati- who have requested, has granted, an exem- COVID-19 vaccination (viii) A process for en- documentation, which clinical contraindication and which supports st exemptions from vacci- and dated by a license- the individual request is acting within their re- as defined by, and in applicable State and I ensuring that such do (A) All information spe- authorized COVID-19 contraindicated for the and the recognized cli contraindications; and (B) A statement by the recommending that the exempted from the fa- vaccination requiremen- recognized clinical co (ix) A process for ensi- secure documentation staff for whom COVID	ting and securely /ID-19 vaccination status of obtained any booster doses the CDC; ch staff may request an laff COVID-19 vaccination in an applicable Federal law; cking and securely lion provided by those staff and for whom the facility option from the staff in requirements; suring that all confirms recognized ons to COVID-19 vaccines taff requests for medical cination, has been signed ed practitioner, who is not ing the exemption, and who espective scope of practice accordance with, all ocal laws, and for further cumentation contains: ecifying which of the vaccines are clinically e staff member to receive inical reasons for the d a authenticating practitioner the staff member be cility's COVID-19 ents for staff based on the ntraindications;	F 888	3		

Facility ID: 475027

If continuation sheet Page 114 of 125

		D HUMAN SERVICES				O. 0938-0391
CENTER	S FOR MEDICARE & N	MEDICAID SERVICES		and the second se	T	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		475027	B. WING		C 10/14/2022	
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RENNING	TON HEALTH & REHAB			BLACKBERRY LANE		
BEIMMING	TON THE ACT IN A RELIAD		E	BENNINGTON, VT 05201		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
ii ii						6
F 888	individuals with acute COVID-19, and individues for COVID-19 treatment (x) Contingency plans vaccinated for COVID Effective 60 Days After §483.80(i)(3)(ii) A pro- staff specified in parage are fully vaccinated for those staff who have be the vaccination require those staff for whom Co- be temporarily delaye CDC, due to clinical po- considerations; This REQUIREMENT by: Based on interview a facility failed to verify	recautions and ling, but not limited to, illness secondary to duals who received s or convalescent plasma ent; and 6 for staff who are not fully 0-19. er Publication: . breess for ensuring that all graph (i)(1) of this section or COVID-19, except for been granted exemptions to ements of this section, or COVID-19 vaccination must d, as recommended by the	F 888			
	staff. Per review of the facil IC604 COVID-19 Vac National Healthcare S website, 3 different en other documentation of	ities staff vaccination policy cination dated 11/15/21, the Safety Network (NHSN) nployee vaccine lists and revealed discrepancies with				
	with the Infection Con 10/13/22 01:20 PM, " ⁻ staff with exemptions. again, these two staff	ination status. Per interview trol Preventionist on There are 2 unvaccinated Now that we are Genesis are grandfathered in, but e must be vaccinated upon				

Facility ID: 475027

If continuation sheet Page 115 of 125

	S FOR MEDICARE &	1		E CONSTRUCTION	(3) DATE SURVEY	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			C	
			DOILDING	- 00 / CDN / 000 V V0		
	475027		B. WING		10/14/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	NONDER OR GOT LER			2 BLACKBERRY LANE		
BENNING	TON HEALTH & REHAB			BENNINGTON, VT 05201		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 888	Continued From pag	e 115	F 888	3		
		a list of TLC nursing				
		cy staff that consists of a				
		censed Nurses Assistants				
		and a copy of an Email to				
	U V.	/13/22 time stamped				
		vaccination verification for	-			
		the list. Upon entrance to			1	
		ng of day one of survey cording to the facilities actual				
		enesis Daily Placement			1	
	Sheet" there were a	handful TLC staff working.				
		edule sent via email from				
	the agency dated 10/		-			
		these 16-nursing staff were				
1		/22. The ICP and a Regional				
		nfirmed that staff vaccination				
1		led on 10/10/2022 as				
		on 10/12/22, and that a list				
		5 (10/13/22) at 1:00PM of				
		ot include agency staff. It s day, that the facility did not				
		ns status for 16 TLC nursing				
		orking in the building. A new				
		ided on day 6 of the survey				
9	(10/14/22).	· ·	17			
F 908 SS=F	Essential Equipment, CFR(s): 483.90(d)(2)	Safe Operating Condition	F 908	1 900		
				The shower/tub room has be	en	
		in all mechanical, electrical,		cleaned and tile floor has be		
		pment in safe operating		repaired. The PVC shower bed	in	
	condition.	is not met as evidenced		disrepair has been removed.		
	by:	IS NOT THET AS EVIDENCED		The state bar to see to see 4	of	
		n and interview, it was		Identified kitchen issues in need	01	
		acility failed to ensure all		cleaning or repair have been		
		nt was maintained in safe		corrected.		
	operating condition.					

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Facility ID: 475027

If continuation sheet Page 116 of 125

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		C		
	475027	B, WING			10/14/2022	
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
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ION HEALTH & REHAB			BENNINGTON, VT 05201			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETH DATE	
1.) Observation on 1 tub/shower/whirlpool area that was separa area and a whirlpool tub/shower/whirlpool area that was noted to many broken tiles, so most of the grout that tiles was gray, black, of the tub/shower/wh the first shower area that revealed a PVC shower bed with thick mattress that was in or the plastic foam cove and a piece of clear p foam mattress. Upor mattress, it was noted applied pressure a cl foam mattress. Interview on 10/9/22 emergency response the shower room was as noted above, and for the oncoming shiff identified concerns. Interview on 10/9/22 staff nurse who had r response nurse, who aware the equipment confirmed the slits in mattress which expos She/he also confirme tub/shower/whirlpool	0/9/22 at 9:08 PM of the room revealed a shower ted from a second shower tub area. Upon entering the room to the left is a shower o be dirty, the floor had ome missing pieces of tile, twas between the remaining or yellow in color. To the left infpool room, to the right of was a second shower area (polyvinyl chloride) pipe c plastic foam covered disrepair. The headrest of red mattress revealed 3 slits obastic tape that exposed the n touch of the foam d to be moist and with a little ear liquid oozed out of the at 9:30 PM with the nurse, who confirmed that a mess, had several issues that s/he would leave a note t nurse to address these at 1:00 AM with a facility elieved the emergency stated she/he was not was in disrepair but the plastic covering of the sed the foam mattress. d that the	F9	 be affected by the deficiency practice. Education will be provided Maintenance Director and Maintenance Director and Maintenance staff on room aintenance. Education will be provided dietary staff on policy Haregarding food service ended will be cleaned, sanitized working order. Audits will be conducted Environment to include preventative/routine maintenance weekly X3 then Monthle Audits will be conducted sanitation, equipment cleaned sanitation, equipment cleaned soft the audits reported and reviewed a Committee Meeting Monthly X3. The results of the audits reported and reviewed a Committee Meeting Monthly X3. 	ient ded to the nd utine led to the CSG027, quipment d and in d on the ntenance y X3. d on kitchen canliness and rder Weckly will be t the QAPI nthly X4 cated. ed by the ce.	20/1970	
	SFOR MEDICARE & FOR MEDICARE & FOEFICIENCIES CORRECTION COVIDER OR SUPPLIER ON HEALTH & REHAB SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page 1.) Observation on 1 tub/shower/whirlpool area that was separa area and a whirlpool tub/shower/whirlpool area that was noted t many broken tiles, sc most of the grout that tiles was gray, black, of the tub/shower/whirlpool area that was noted t many broken tiles, sc most of the grout that tiles was gray, black, of the tub/shower area that revealed a PVC shower bed with thick mattress that was in or the plastic foam cover and a piece of clear p foam mattress. Upor mattress, it was noted applied pressure a clifoam mattress. Interview on 10/9/22 emergency response the shower room was as noted above, and for the oncorning shiff identified concerns. Interview on 10/9/22 staff nurse who had r response nurse, who aware the equipment confirmed the slits in mattress which exposes She/he also confirme	CORRECTION IDENTIFICATION NUMBER: 475027 TOVIDER OR SUPPLIER TON HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 116 1.) Observation on 10/9/22 at 9:08 PM of the tub/shower/whirlpool room revealed a shower area that was separated from a second shower area and a whilpool tub area. Upon entering the tub/shower/whirlpool room to the left is a shower area that was noted to be dirty, the floor had many broken tiles, some missing pieces of tile, most of the grout that was between the remaining tiles was gray, black, or yellow in color. To the left of the tub/shower/whirlpool room, to the right of the first shower area was a second shower area that revealed a PVC (polyvinyl chloride) pipe shower bed with thick plastic foam covered mattress that was in disrepair. The headrest of the plastic foam covered mattress revealed 3 slits and a piece of clear plastic tape that exposed the foam mattress. Upon touch of the foam mattress, it was noted to be moist and with a little applied pressure a clear liquid oozed out of the foam mattress. Interview on 10/9/22 at 9:30 PM with the emergency response nurse, who confirmed that the shower room was a mess, had several issues as noted above, and that s/he would leave a note for the oncoming shift nurse to address these identified concerns. Interview on 10/9/22 at 1:00 AM with a facility staff nurse who had relieved the emergency response nurse, who stated she/he was not aware the equipment was in disrepair but confirmed the slits in the plastic covering of the mattress which exposed the foam mattress. She/he also confirmed that the tub/shower/whirlpool room was dirty, tiles were	S FOR MEDICARE & MEDICAID SERVICES PEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN 475027 DOVIDER OR SUPPLIER 475027 B. WING COVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D Continued From page 116 FG 1.) Observation on 10/9/22 at 9:08 PM of the tub/shower/whiripool room revealed a shower area that was separated from a second shower area that was noted to be dirty, the floor had many broken tiles, some missing pieces of tile, most of the grout that was between the remaining tiles was gray, black, or yellow in color. To the left of the tub/shower/whiripool room, to the right of the first shower area was a second shower area that revealed a PVC (polyvinyl chloride) pipe shower bed with thick plastic foam covered mattress that was in disrepair. The headrest of the plastic foam covered mattress revealed 3 slits and a piece of clear plastic tape that exposed the foam mattress. Upon touch of the foam mattress. Interview on 10/9/22 at 9:30 PM with the emergency response nurse, who confirmed that the shower room was a mess, had several issues as noted above, and that s/he would leave a note for the oncerns. Interview on 10/9/22 at 1:00 AM with a facility staff nurse who had relieved the emergency response nurse, who stated she/he was not aware the equipment was in disrepair but confirmed the slits in the plastic covering of the mattress which exposed the foam mattress. She/he also confirmed that the tub/shower/whirlpool room was dirty, tiles were	SPOR MEDICARE & MEDICAID SERVICES #DEFIGURATE & MEDICATO SERVICES #DEFIGURATES (X1) PROVIDENSUPPLIER 1000000000000000000000000000000000000	SFOR MEDICARE & MEDICAD SERVICES OMB NC PERFORMES (X1) PROMORENSUPPLICATION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A DULDING 475027 (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION OWDER OR SUPPLER 2 BLACKBERY LANE 2 BLACKBERY LANE CONTINUED FOR DEFICIENCIES 2 BLACKBERY LANE 2 BLACKBERY LANE SUMMARY STREAM OF DEFICIENCIES CONTINUED IN ORDERISTING AND CORRECTION PROVINCE'S LAN OF CORRECTION Continued From page 116 1.) Observation on 10/9/22 at 9:00 PM of the tub/shower/whilrpool room to the left is a shower area and a whilrool tub area. Upon entering the tub/shower/whilrpool room, to the left is a shower area and a whilrool tub area. Upon entering the tub/shower/whilrpool room to the left is a shower area and a whilrool tub area. Upon entering the tub/shower/whilrpool room to the left is a shower area and a second shower area area sea second shower area and a whilrool tub area. Upon entering the tub/shower/whilrpool room to the left is a shower area and a whilrool tub area. Shower bad writes shower area and a whilrool tub area. Shower bad writes shower area and a whilrool tub area. Shower bad writes shower area and a whilt hick plastic foam covered mattress. The headrest of the plastic to and covered mattress. If was noted to be drived at an other antites will be conducted on the fany mattress. How area in disrepair. The headrest of the plastic to and covered mattress. How area in a second shower area and a whilth a little applied pressure a clear inpud occed out of the foam mattress. Interview on 10/9/22 at 9:30 PM with the emergency response nurse, who c	

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED C	
	475027	8, WING				10/14/2022	
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TON HEALTH & REHAB							
(EACH DEFICIENC)	COMMAND STATEMENT OF DEFINITIONS IN THE PRECEDED BY FILL PREFIX (EACH CORRECTIVE ACTION SHO		HOULD BE	(X5) COMPLE DATE			
Continued From page	117	F 90	08				
survey team did a wa main kitchen with the	kthrough of the facility's ICP (Infection Control						
observed and confirm	ed by the ICP person at the			Сř			
cracked all the way an container just above w	ound the bottom of the						
b.) The food pur cracked all the way an container just above w	ound the bottom of the						
c.) An air conditi the windows across fr mixer, puree machine	om the table where the and various other				1.4		
conditioner was noted substance on the from	l to have a thick and sticky t grill where the cool air						
environment. Within t substance was noted insects.	his thick and sticky some hair, dust, and						
have large holes that marks. When asked a	appeared to have teeth about these holes and						
Food Service Director supervisor responded	(FSD) and her/his that the rats had chewed						
storage tubs where di	y goods/foods are being						
kitchen with the FSD walk-through of the ki	and her/his supervisor. A tchen occurred and						
	S FOR MEDICARE & M OF DEFICIENCIES CORRECTION ROWDER OR SUPPLIER TON HEALTH & REHAB SUMMARY ST. (EACH DEFICIENCY REGULATORY OR L Continued From page survey team did a wal main kitchen with the Preventionist), the foll observed and confirm time of these observa a.) The food purc cracked all the way ar container just above v inside the pitcher. b.) The food purc cracked all the way ar container just above v inside the pitcher. b.) The food purc cracked all the way ar container just above v inside the pitcher. c.) An air condition the windows across fr mixer, puree machine equipment for food pro- conditioner was noted substance on the from comes out of the conce environment. Within t substance was noted insects. d.) Several plast have large holes that marks. When asked a quetionable teeth mar Food Service Director supervisor responded through the covers of storage tubs where dr kept since the mice ar Observation on 10/10 kitchen with the FSD a walk-through of the kii revealed the above fir	IDENTIFICATION NUMBER: 475027 ATOM HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 117 survey team did a walkthrough of the facility's main kitchen with the ICP (Infection Control Preventionist), the following issues were observed and confirmed by the ICP person at the time of these observations: a.) The food puree machine pitcher was cracked all the way around the bottom of the container just above where the blades are located inside the pitcher. b.) The food puree machine pitcher was cracked all the way around the bottom of the container just above where the blades are located inside the pitcher. c.) An air conditioner was observed in one of the windows across from the table where the mixer, puree machine and various other equipment for food prep were stored. The air conditioner was noted to have a thick and sticky substance on the front grill where the cool air comes out of the conditioner and into the environment. Within this thick and sticky substance was noted some hair, dust, and insects. d.) Several plastic tub lids were noted to have teeth marks. When asked about these holes and quetionable teeth marks in the identified lids, the Food Service Director (FSD) and her/his supervisor responded that the rats had chewed through the covers of some of the heavy-duty storage tubs where dry goods/foods are being kept since the mice and rat issue started. <td 10="" 22="" 8:45="" a="" above="" am="" and="" at="" colservation="" findings="" from="" fsd="" her="" his="" kitchen="" occurred="" of="" on="" revealed="" supervisor.="" td="" the="" the<="" walk-through="" with=""><td>S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A BUILDING 475027 B. WING</td><td>S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION IDENTIFICATION NUMBER: A BULDING 475027 ROWDER OR SUPPLIER TON HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WILL BEFCREEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) REQULATORY OR LSC IDENTIFYING INFORMATION Continued From page 117 SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION Continued From page 117 SURVey team did a walkthrough of the facility's main kitchen with the ICP (Infection Control Preventionist), the following issues were observed and confirmed by the ICP person at the time of these observations: a.) The food purce machine pitcher was cracked all the way around the bottom of the container just above where the blades are located inside the pitcher. b.) The food purce machine pitcher was cracked all the way around the bottom of the container just above where the blades are located inside the pitcher. c.) An air conditioner was observed in one of the windows across from the table where the mixer, purce machine and various other equipment for food prey were stored. The air conditioner was noted to have a thick and sticky substance was noted some hair, dust, and insects. d.) Several plastic tub lids were noted to have large holes that appeared to have teath marks. When asked about these holes and quetionable teath marks i</td><td>S FOR MEDICARE & MEDICAID SERVICES SFDERENCISS (X) PROVIDERSUPPLIERCUA (X) MULTIPLE CONSTRUCTION A DULDING </td><td>NUMBER OF INDUCTARE & MEDICARD SERVICES OMB h SPECENCENCES (N) PROVIDERSUPPLERCIA IDENTIFICATION NUMBER pt23MULTPLE CONSTRUCTION A BULDING (N) PROVIDERSUPPLERCIA IDENTIFICATION NUMBER ADUDRER OR SUPPLIER at5027 E. 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WING</td> <td>S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION IDENTIFICATION NUMBER: A BULDING 475027 ROWDER OR SUPPLIER TON HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WILL BEFCREEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) REQULATORY OR LSC IDENTIFYING INFORMATION Continued From page 117 SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION Continued From page 117 SURVey team did a walkthrough of the facility's main kitchen with the ICP (Infection Control Preventionist), the following issues were observed and confirmed by the ICP person at the time of these observations: a.) The food purce machine pitcher was cracked all the way around the bottom of the container just above where the blades are located inside the pitcher. b.) The food purce machine pitcher was cracked all the way around the bottom of the container just above where the blades are located inside the pitcher. c.) An air conditioner was observed in one of the windows across from the table where the mixer, purce machine and various other equipment for food prey were stored. The air conditioner was noted to have a thick and sticky substance was noted some hair, dust, and insects. d.) Several plastic tub lids were noted to have large holes that appeared to have teath marks. When asked about these holes and quetionable teath marks i</td> <td>S FOR MEDICARE & MEDICAID SERVICES SFDERENCISS (X) PROVIDERSUPPLIERCUA (X) MULTIPLE CONSTRUCTION A DULDING </td> <td>NUMBER OF INDUCTARE & MEDICARD SERVICES OMB h SPECENCENCES (N) PROVIDERSUPPLERCIA IDENTIFICATION NUMBER pt23MULTPLE CONSTRUCTION A BULDING (N) PROVIDERSUPPLERCIA IDENTIFICATION NUMBER ADUDRER OR SUPPLIER at5027 E. WNO 1 NOMDER OR SUPPLIER STREETADDRESS, CITY, STATE, ZIP CODE 2 BLACKBERRY LINE EXCHOLEDICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DERTIFYING INFORMATION STREETADDRESS, CITY, STATE, ZIP CODE 2 BLACKBERRY LINE EXCHOLEDICIENCY MUST BE PRECEDEND BY FULL REGULATORY OR LSC DERTIFYING INFORMATION PROVIDERS PLAN OF CORRECTION EACH CONSISTED SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEND BY FULL REGULATORY OR LSC DERTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION EACH CONSISTED SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEND BY FULL REGULATORY OR LSC DERTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CONSISTED SUMMARY STATEMENT OF DEFICIENCIES (EACH DETICIENCY MUST BE PRECEDEND BY FULL REGULATORY OR LSC DERTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CONSTITUE AT THE EACH DETICIENCY MUST BE PRECEDEND BY FULL REGULATORY OR LSC DERTIFY THIS INFORMATION) PROVIDERS ACTIVE AT THE DETICIENCY (EACH DETICIENCY MUST BE PRECEDEND BY FULL REGULATORY OR LSC DERTIFY THIS INFORMATION PROVIDERS ACTIVE AT THE DETICIENCY (EACH DETICIENCY MUST BE PRECEDEND BY FULL REGULATORY OR LSC DERTIFY THIS INFORMATION PROVIDERS ACTIVE AT THE EACH DETICIENCY MUST BE PRECEDENT AT SUMMARY STATEMENT OF DEFICIENCY (EACH DETICIENCY MUST BE AT THE AT THE AT THE AT THE AT (EACH DETICIENCY MUST BE AT THE AT THE AT THE AT THE AT THE AT THE AT (EACH DETICIENCY MUST BE AT THE AT THE AT THE AT THE AT THE AT THE AT (EACH DETICIENCY AT THE AT THE AT THE AT THE AT THE AT THE AT TH</td>	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A BUILDING 475027 B. WING	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION IDENTIFICATION NUMBER: A BULDING 475027 ROWDER OR SUPPLIER TON HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WILL BEFCREEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) REQULATORY OR LSC IDENTIFYING INFORMATION Continued From page 117 SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION Continued From page 117 SURVey team did a walkthrough of the facility's main kitchen with the ICP (Infection Control Preventionist), the following issues were observed and confirmed by the ICP person at the time of these observations: a.) The food purce machine pitcher was cracked all the way around the bottom of the container just above where the blades are located inside the pitcher. b.) The food purce machine pitcher was cracked all the way around the bottom of the container just above where the blades are located inside the pitcher. c.) 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WNO 1 NOMDER OR SUPPLIER STREETADDRESS, CITY, STATE, ZIP CODE 2 BLACKBERRY LINE EXCHOLEDICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DERTIFYING INFORMATION STREETADDRESS, CITY, STATE, ZIP CODE 2 BLACKBERRY LINE EXCHOLEDICIENCY MUST BE PRECEDEND BY FULL REGULATORY OR LSC DERTIFYING INFORMATION PROVIDERS PLAN OF CORRECTION EACH CONSISTED SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEND BY FULL REGULATORY OR LSC DERTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION EACH CONSISTED SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEND BY FULL REGULATORY OR LSC DERTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CONSISTED SUMMARY STATEMENT OF DEFICIENCIES (EACH DETICIENCY MUST BE PRECEDEND BY FULL REGULATORY OR LSC DERTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CONSTITUE AT THE EACH DETICIENCY MUST BE PRECEDEND BY FULL REGULATORY OR LSC DERTIFY THIS INFORMATION) PROVIDERS ACTIVE AT THE DETICIENCY (EACH DETICIENCY MUST BE PRECEDEND BY FULL REGULATORY OR LSC DERTIFY THIS INFORMATION PROVIDERS ACTIVE AT THE DETICIENCY (EACH DETICIENCY MUST BE PRECEDEND BY FULL REGULATORY OR LSC DERTIFY THIS INFORMATION PROVIDERS ACTIVE AT THE EACH DETICIENCY MUST BE PRECEDENT AT SUMMARY STATEMENT OF DEFICIENCY (EACH DETICIENCY MUST BE AT THE AT THE AT THE AT THE AT (EACH DETICIENCY MUST BE AT THE AT THE AT THE AT THE AT THE AT THE AT (EACH DETICIENCY MUST BE AT THE AT THE AT THE AT THE AT THE AT THE AT (EACH DETICIENCY AT THE AT THE AT THE AT THE AT THE AT THE AT TH

	AENT OF HEALTH AN	D HUMAN SERVICES				FORM OMB NO	: 10/31/2022 APPROVED .0938-0391	
STATEMENT C	ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED C 10/14/2022	
		475027	B, WING	2 BL	EET ADDRESS, CITY, STATE, ZIP CODE			
BENNING (X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FOLL			BEN	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE	
TAG F 908 F 925 SS=F	Continued From page Interview on 10/10/22 with the FSD and her confirmed the above Maintains Effective P CFR(s): 483.90(i)(4) §483.90(i)(4) Mainta program so that the rodents. This REQUIREMEN' by: Based on observation review, it was determ maintain an effective ensures the facility is Findings include: Tour on 10/9/22 at a second floor, revealed nurses station that re on the wall to the left clipboard contained CHECK DATE LOG information document "8/15/22 small rat ov 8/16/22 med rat diet	e 118 2 at approximately 9:45 AM /his supervisor, both findings. est Control Program in an effective pest control facility is free of pests and T is not met as evidenced on, interview, and record nined that the facility failed to pest control program that is free of pests and rodents. pproximately 8:35 PM of the ed a small room behind the evealed a clipboard hanging of the room entrance. The a form that was titled, "TRAP 2022" with the following nted: er cooler; office;	F S	908	F 925 The facility is contracted with control vendor for appropriate ongoing services. All Residents have the potentia affected by the deficient practi Education will be provided to s regarding environmental clean proper food storage. Education will be provided to t Maintenance staff on Infection Control policy 1.5 specific to I control. Education will be provided dietary staff on HCSG policy 0 pest control. Education will be provided to nursing staff on reporting pest	al to be ce. staff ing and he Pest to the 29 for the		
	10/3/22 checked tra 10/10/22 checked tra 9/7/22 check all; 9/16/22 check all; 9/23/22 check all; 9/30/22 check all; 9/30/22 check all" The third floor Pest 9/19/2022 that state ceiling at nursing sta	aps all; Log had one entry on d "RT (Rat) Caught in trap in			management issues in the TEI system. Audits will be conducted on environmental cleanliness, pe control process and pest contr monitoring and use of TELs to report pest control is	_s st ol		

Facility ID: 475027

If continuation sheet Page 119 of 125

		D HUMAN SERVICES			PRINTED: 10/31/2022 FORM APPROVED OMB NO: 0938-0391
STATEMENT	S FOR MEDICARE & M PF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		475027	B. WING		C 10/14/2022
NAME OF PR	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	
				2 BLACKBERRY LANE	
BENNING	TON HEALTH & REHAB			BENNINGTON, VT 05201	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 925	written above. Observation on 10/9/2 floor dining area reveat the resident dining area *tray with dirty dis *dirty refrigerator on the shelves and or shelves; *11 pieces of che plastic wrapped, that corner of each piece; *cabinet drawers disposables (small pa sizes of tinfoil, packet binder clip) scattered what appeared to be of these items. *Another drawer lids, some in the plast many out of the sleev the drawer, an individ and various single sel what appeared to be of these items. *dirty microwave; *large metal mou utility rack in the kitch *a rat trap located and the wall of the kitter Observation on 10/10	d form was not in nd was documented as is 22 at 9:41 PM of the second aled the following issues in ea and kitchenette: shes and exposed food; and freezer with spills inside the inside of the door ease partially wrapped in are curled and dried on one with miscellaneous kitchen uper bags, pieces of various s of tea, hot cocoa and a through the drawer and coffee grounds mixed in with with small plastic disposable tic protective sleeve and e and scattered throughout ual package of crackers, rve condiment packets, and coffee grounds mixed in with se trap noted under the a enette serving area; d between the refrigerator chenette serving area. //22 at 8:15 AM revealed the fentified on 10/9/22 at 9:41	F 925	Weekly X3 then Monthly 3 The results of the audits will reported and reviewed at the Committee Meeting Monthly further evaluation if needed. Oversight will be provided b Administrator or designee. F935 PoL accepted ulplzz	be QAPI YX4 y
		at 8:45 AM with the Food			
	(02.00) Pravious Versions Obso	Eveni ID:J85X1	1 F	acility ID: 475027 If continu	ation sheet Page 120 of 125

CENTER	S FOR MEDICARE 8	MEDICAID SERVICES				OMB	10.0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA (X2)		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED C	
		475027	B, WING					
		475027	B, WING		STREET ADDRESS, CITY, STATE, ZIP CODE		0/14/2022	
	ROVIDER OR SUPPLIER	B		2 BL	ACKBERRY LANE			
DEMMING	TON REACTING RENA			BEN	ININGTON, VT 05201		_	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 925	Continued From par Service Director (FS who confirmed the a that some parts of t areas are the respo some by nursing. Observation on 10/ AM during a kitcher with the FSD and he numerous food sout the corner of the kite entrance/exit door a hallway, was a stick covered with variou closer inspection th spiders, flies (large insects and dirt. To a large metal mouse above-mentioned st that was dark brown yellow, black, and re was wet with a clea from the sticky trap encompassed this u object could not be survey team or the Control Preventioning glove and picked up item/substance and piece of petrified sa The mouse traps we and FSD Superviso mice in the facility. they had seen any re	ge 120 SD) and FSD's Supervisor, above findings. They stated he kitchenettes and serving nsibility of housekeeping and 10/22 at approximately 8:50 in walk-through/kitchen tour er/his supervisor revealed rces for pests and rodents. In chen, behind the 2nd at opened to the first floor ty mouse trap that was s sizes of black spots. Upon ese black spots were ants, and small), and various other the left of the sticky trap was etrap. In front of the ticky trap was a substance n with variations of brown, ed. This substance appeared to be sitting in an area that r grayish color that extended and mouse trap and unidentified brown object. The identified on 10/9/22 by the accompanying Infection st (ICP). The FDS put on a o the unidentified I said she/he thought it was "a		925				
	to store and protect plastic tub lids were	food from rodents. Several						

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES					M APPROVED O. 0938-0391	
the local day is a second based on the second		MEDICAID SERVICES	(X2) MULT	IPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				A BUILDING				
							С	
		475027	B. WING			1)/14/2022	
NAME OF PE	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE			
					ACKBERRYLANE			
BENNING	TON HEALTH & REHAB			BEN	NINGTON, VT 05201		1	
04010	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO	CTION DULD BE	(X5) COMPLETION	
(X4) ID PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX TAG	<	CROSS-REFERENCED TO THE APP	ROPRIATE	DATE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)			DEFICIENCY)			
		101	F	925				
F 925	Continued From page	e 121		120			1	
	that appeared to have	e teeth marks. When asked	1	- 2				
	about these holes an	d questionable teeth marks						
	both staff responded	that the rats had chewed nd some of the heavy-duty		1				
	storage tubs. A mou	se trap was observed in the					l	
8	dry storage area und	er a commercial utility rack						
	along with a square t	plack box. When asked what						
	this box was, the FSI	D Supervisor picked it up and						
	looked it over and sa	id she/he didn't really know						
	but said she/he woul	d get the maintenance man						
	to help figure it out.	At approximately 9:15 AM a						
	maintenance staff pe	erson came to the dry storage						
	area and explained t	hat the black box was a "bait firmed that the facility has						
	box" for rats and con	is and a professional		-				
	company had been i	nvolved but now the						
	maintenance depart	ment was responsible for						
	checking the traps.	The maintenance staff was						
	asked if she/he had	actually seen rats in the						
	building and she/he	responded with, "yes". When						
	asked when the last	time was that she/he saw a						
	rat in the building an	d where she/he saw the rat, month we caught a large one						
	in the rat trap in the	ceiling above the second						
	floor nurses station."	" She/he was asked to						
	explain the "bait box	" and how that works.						
	She/he stated that th	he maintenance department						
	does not have acces	ss to the bait boxes but that						
	Ipest control compa	ny name] had placed these						
	boxes throughout th	e inside and outside of the						
	facility and that they	were the only ones who					÷	
	could open these bo	oxes to refill them with bait for ed how often the pest control						
	the rats. When aske	ese traps, the maintenance						
	person stated that s	he/he believed it was several						
	times a week but the	at they hadn't been there						
	since some time this	s past August due to a						
	disagreement betwee	een the pest control company						
	and the facility "sorr	nething to do with payment".						

Event ID: JB5X11

Facility ID: 475027

If continualion sheet Page 122 of 12

ENTERS	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			NO. 0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A BUILDING		(X3) DATE SURVEY COMPLETED C	
		475027	B. WING		10/14/2022
INTE OF D	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
	TON HEALTH & REHA	ъ		BLACKBERRY LANE ENNINGTON, VT 05201	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R 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 925	Continued From pa	age 122	F 925		
	with the Director C there are many mo the building and ou explained that there the facility and the regarding an outst that she/he believe previous manager management was particulars regardi Copies of pest com pest control comp	/22 at approximately 11:15 AM of Maintenance confirmed that buse and rat traps throughout utside the building. She/he e was a disagreement between pest control company anding bill. She/he explained ed the \$6,000 bill was from the nent and that the new trying to work out the ng the past due amount. ttrol reports revealed that the any was last in the building in August of 2022.			
F 943 SS=F	10/14/22 at 10:24 [name of pest con yesterday" She// issue with paymer control company] to the facility since stated that she/he credit card and a in Abuse, Neglect, a CFR(s): 483.95(c) §483.95(c) Abuse In addition to the facilities must also that at a minimum §483.95(c)(1) Act neglect, exploitation	with the facility Administrator on AM who confirmed that "the trol company] came in the explained that there was an that and that is why [name of pest has not been providing services this past August - she/he paid them with her/his personal new contract was in process. and Exploitation Training 0(1)-(3) , neglect, and exploitation. reedom from abuse, neglect, equirements in § 483.12, o provide training to their staff reducates staff on- ivities that constitute abuse, on, and misappropriation of as set forth at § 483.12.	F 943	F 943 The 15 Emergency response contracted staff are no longer working at the facility. All Residents have the potential to b affected by the deficient practice.	be

Event ID: JB5X11

Facilly ID: 475027

FORMAPPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION C 10/14/2022 R WING 475027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2 BLACKBERRY LANE **BENNINGTON HEALTH & REHAB** BENNINGTON, VT 05201 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 1D (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Education will be provided to F 943 Continued From page 123 F 943 staff on Abuse Prohibition policy §483.95(c)(2) Procedures for reporting incidents OPS300 with a post test. of abuse, neglect, exploitation, or the misappropriation of resident property Audits will be conducted on Abuse training with newly hired or §483.95(c)(3) Dementia management and contracted staff to ensure staff resident abuse prevention. This REQUIREMENT is not met as evidenced have received Abuse training. Weekly X3 then Monthly X3. by: Based on interviews and record review the facility failed to provide training to all staff that at a The results of the audits will be minimum educates staff to include reported and reviewed at the QAPI agency/contract staff on activities that constitute Committee Meeting Monthly X4 abuse, neglect, exploitation, and misappropriation further evaluation if indicated. of resident property. Findings include: Oversight will be provided by the Administrator or designee. While investigating an allegation of abuse, staff F943 POL accepted 11/7/22 SFreeman Rul Prue training records specific to abuse, neglect, exploitation, and misappropriation of resident property were requested and reviewed. The Staff Educator and Infection Preventionist were interviewed on 10/11/22 at 1030 AM, it was revealed that the facility uses agency staffing to fill projected vacancies and emergency temporary agency staffing during the current Covid-19 outbreak. When questioned regarding the qualifications and competencies of the emergency staff the Infection Preventionist replied "aside from getting them computer access we don't even know who they are". Records regarding training for the agency staff were obtained by the facility from the agency per surveyor's request, the records provided included self-assessments and contained various check lists of education related to competencies without evidence of measurable patterns of knowledge related to abuse, neglect, exploitation, or misappropriation of resident property. If continuation sheet Page 124 of 125 Facility ID: 475027 Event ID: JB5X11

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

		D HUMAN SERVICES				OM	NTED: 10/31/ FORM APPRC B NO. 0938-1
ATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMDER:			CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		475027	B. WING				10/14/2022
NAME OF PR	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2			
SENNING	TON HEALTH & REHAB			В	SENNINGTON, VT 05201		
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F 943	Continued From page	124	F	943			
	provided by the facility response staff which Licensed Nursing Ass	emergency response staff					
-	emergency responde that the facility provide assessed for compete prevention or respons resident assignment. 10/13/2022 at 10:46 A	rs there was no evidence ed training or were ency related to abuse e prior to assuming a During an interview on M the staff educator					
	confirmed that the 15 not receive training, n competencies related	emergency responders did or were they assessed for to abuse.			S. III		
		05					
		ata Event ID: JB5X			iłity ID: 475027 lf cc		eet Page 125 o