VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

May 8, 2023

Mr. Edwin Rojas, Administrator
Bennington Health & Rehab
2 Blackberry Lane
Bennington, VT 05201-2300

Dear Mr. Rojas:

Enclosed is a copy of your acceptable plans of correction for the investigation survey conducted on **April 14, 2023.** Please post this document in a prominent place in your facility.

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

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced investigation of 6 facility reported incidents was conducted on 4/14/23 by the Division of Licensing and Protection. There were regulatory violations identified as a result of these investigations.	F 000	F00 Please note that the filing of this plan of correction does not constitute admission to any of the alleged violations set forth in this statement of deficiencies. This plan of correction is being filed as evidence of the Facility's continued compliance with all applicable laws.	
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to protect the residents' right to be free from physical and verbal abuse by staff for 3 of 6 sampled residents (Residents #1, #2, and #3). Findings include: 1. Per facility investigation report dated 4/13/2023, victim and staff statements reveal that Resident #1 had told a Registered Nurse (RN) on 4/10/2023 that s/he had been smacked on the hand by Licensed Practical Nurse (LPN) #1 on 4/9/2023 hard enough for it to be painful. The	F 600	F600 1. Licensed Practical Nurse #1 was immediately removed from the schedule. Resident's #1 is no longer in the facility. Resident # 2 & # 3 were interviewed. 2. All Residents have the potential to be affected. Resident and staff interviews were immediately initiated to identify any other residents who may have been affected, no further residents other than those reported by the facility to DAILSC as outlined in this 2567 have been affected. 3. An Emergency Notification List detailing reporting requirements was developed and implemented. All staff have been in-serviced on the Emergency Notification List and Abuse Prohibition and Reporting. 4. Random resident interviews will be conducted weekly X3, then monthly X3 by the Administrator and/or Designee to identify any possible instances of abuse. Random Staff Interviews will be conducted	05/01/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/5/23

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 1 final report of the alleged abuse investigation, completed by the Director of Nursing (DON), substantiated physical abuse to Resident #1 by LPN #1. 2. Per facility investigation report dated 4/13/2023, victim and staff statements reveal that Resident #2 reported that LPN #1 yelled at her/him when s/he requested pain medication. Resident #2 heard LPN #1 state that s/he is "glad I don't have to work down here all the time. I would hate working with them." This was confirmed by Resident #2's roommate, who was woken up by LPN #1 screaming at Resident #2. The final report of the alleged abuse investigation, completed by the DON, substantiated verbal abuse to Resident #2 by LPN #1. On 4/17/2023 at 2:05 PM, Resident #2 described the alleged incident with no deviation from the statement given to the facility. Resident #2's roommate also confirmed the incident occurred as stated by Resident #2. Resident #2 stated that this event made her/him nervous and feel disrespected. 3. Per facility investigation report dated 4/13/2023, victim and staff statements reveal that Resident #3 had reported that LPN #1 was very rude and rough with him/her over the past weekend. Resident #3 was having difficulty with her/his oxygen and LPN #1 was rough and screaming at her/him when requesting assistance. Resident #3 stated that LPN #1 told her/him that s/he would leave and not come back. The final report of the alleged abuse investigation, completed by the DON, substantiated verbal abuse to Resident #3 by	F 600	weekly x 3 then monthly x 3 to test and reeducated staff as needed regarding their response to resident allegations of abuse. The results of the audit will be reported and reviewed at the monthly QAPI Committee meeting X4 months and evaluated as needed. Oversight will be provided by the Administrator and/or Designee. **Tag F 600 POC accepted on 5/5/23 by S. Stem/P. Cota**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 2 LPN #1. On 4/17/2023 at 1:41 PM, Resident #3 stated that LPN #1 had threatened her/him not to help with her/his oxygen machine and was swearing at her/him. S/he stated that s/he felt sick without her/his oxygen, and it made her/him feel scared. S/He felt disrespected by the way the LPN #1 talked to her/him. 4. On 4/17/2023 at 2:30 PM, the Administrator and DON confirmed that LPN #1 did not have appropriate behaviors and the investigations of abuse to Residents #1, #2, and #3 were substantiated.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609	F609 1. Licensed Practical Nurse #1 was removed from the schedule. Day 1 Report was submitted on April 14, 2023. Resident #4 was contacted for a statement. 2. All Residents have the potential to be affected. Resident and staff interviews were immediately initiated to identify any other residents who may have been affected, no further residents other than those reported by the facility to DAILSC as outlined in this 2567 have been affected. 3. An Emergency Notification List detailing reporting requirements was developed and implemented. All staff have been in-serviced on the Emergency Notification List and Abuse Prohibition and Reporting.	05/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 3 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to implement policies and procedures for ensuring the reporting of an alleged violation involving abuse not later than two hours after the allegation is made, to the administrator of the facility and to other officials, including to the State survey and certification agency and adult protective services in accordance with State law for one applicable resident (Resident #4); and failed to report findings of abuse to Licensing Boards for 3 applicable residents (Residents #1, #2, and #3). Findings include: Facility policy titled "OPS300 Abuse Prohibition" states: "6.1 Anyone that witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately, regardless of shift worked. 6.1.1 The notified supervisor will report the suspected abuse immediately to the Administrator or designee and other officials in accordance with state law." "7. Immediately upon receiving information concerning a report of suspected or alleged	F 609	4. Random resident interviews will be conducted weekly X3, then monthly X3 by the Administrator and/or Designee to identify any possible instances of abuse. Random Staff Interviews will be conducted weekly x 3 then monthly x 3 to test and reeducated staff as needed regarding their response to resident allegations of abuse. The results of the audit will be reported and reviewed at the monthly QAPI Committee meeting X4 months and evaluated as needed. Oversight will be provided by the Administrator and/or Designee. 5. LPN License was reported to OPR within the 10 day required time frame as required. Of note is the fact that the Link on the OPR reporting Website was incorrect and after numerous attempts by DON on the 14th, 15th, 16th and the Executive Director on the 17th, the Executive Director was able to contact a person at the OPR web management site who confirmed that the link listed was incorrect and referred him to email the report instead. The report was then successfully submitted and accepted. Tag F 609 POC accepted on 5/5/23 by S. Stem/P. Cota	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 4	F 609		

abuse, mistreatment, or neglect, the Administrator or designee will perform the following ..."
"7.2 Report allegations involving abuse (physical, verbal, sexual, mental) not later than 2 hours after the allegation is made."
"7.5 Notify local law enforcement, Licensing Boards and Registries, and other agencies as required."
"7.7 Initiate an investigation within 2 hours of an allegation of abuse that focuses on:
7.7.1 whether abuse or neglect occurred and to what extent."

1. Per review of facility alleged abuse investigation documentation regarding allegations of abuse regarding Licensed Practical Nurse (LPN) #1, a statement taken by the facility from a Registered Nurse (RN) on 4/10/2023 reveals that LPN #1 had reported to him/her that "[Resident #4] had refused a Foley [catheter], but [LPN#1] had administered it anyway against [his/her] wishes." Conclusion of this statement reveals that the Administrator had educated this RN about the importance of communicating any concerns about patient care or rights immediately to his/her Supervisor, the Director of Nursing (DON), or Administrator. This RN statement was obtained by the Administrator and another staff member. Investigation documentation also reveals that 3 alleged abuse investigations had substantiated that LPN #1 was abusive to other residents (Residents #1, #2, and #3) approximately one week after the incident above. See F600 for additional information regarding abuse findings.

Per interview with the Administrator and DON on 4/14/2023 at 2:30 PM it was determined that this event must have taken place sometime during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 5 the first weekend of April because LPN #1's was hired on 3/27/2023, was scheduled to work weekend shifts, and Resident #4 was discharged from the facility on 4/6/2023. The DON and Administrator confirmed that this RN did not report this event prior to 4/10/2023. The DON also confirmed that the facility did not report this allegation to the State Agency or Adult Protective Services because s/he would like to talk to the resident before they start an investigation or report it to any agency. 2. Per review of facility alleged abuse investigation documentation, the facility had substantiated abuse to Residents #1, #2, and #3. All three investigations, dated and signed by the DON on 4/13/2023, state that LPN #1 "no longer works for this center and has been reported to the VT Board of Registration in Nursing." On 4/18/23 at 3:47 PM a request for a copy of the report to the Office of Professional Regulation [OPR; VT Board of Registration in Nursing] was made to the Administrator. At this time, the Administrator stated that LPN #1 has not yet been reported to OPR for abuse to Residents #1, #2, and #3.	F 609		