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

June 10, 2024

Ms. Tabitha Davis-Barron, Administrator
Bennington Health & Rehab
2 Blackberry Lane
Bennington, VT 05201-2300

Dear Ms. Davis-Barron:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **May 2, 2024.** 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,

PamelaMCotaRN
Pamela M. Cota, RN
Licensing Chief

Enclosure

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 05/02/2024

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 The Division of Licensing and Protection conducted an unannounced, onsite complaint investigation of report #22901 & #22641 on 5/1-5/3/2024 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. There were regulatory deficiencies cited as a result of this survey.	F 000	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 law.	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §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 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550	1.This event occurred in the past and was corrected 2. All residents have the potential to be affected, resident interviews will be conducted with all residents to ensure they feel they are being treated with respect and dignity. 3.All staff will be educated on the resident rights policy OPS206 to ensure residents are treated with respect and dignity and are provided care in a manner and in an environment that promotes maintenance or enhancement of quality of life, recognizing each resident as an individual. That they have equal access to quality care regardless of payment source, severity of condition or diagnoses, including for provision of discharges and transfer/discharge and are able to exercise rights as a resident of the facility as well as a citizen/resident of the United States without interference, coercion, discrimination or reprisal from the facility 4.Audits of resident rights will be done through observation and partner program interviews of residents rights being followed throughout the facility. These audits will be done weekly x3 weeks, biweekly x 3, and monthly x3. All outcomes will be discussed at Qapi.	6/13/24

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

LNHA — Administrator — 6/7/24

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

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F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that a resident's right to be treated with dignity and respect was maintained for 1 of 3 residents in the sample (Resident #1). Findings include: During an interview on 5/1/24 at approximately 12:35 PM Resident #1 stated, "I have lost my rights as a person, and I feel like I am being targeted ... The previous Director of Nursing (DON) hung letters about me at the nurse's station and had things in my care plan that were not true." The resident was visibly upset about the content of the letters, stating s/he "felt humiliated that this note was hung for everyone to see." Resident #1 also said that months ago a Nurse who is now the Interim DON had called the police on her/him because s/he got angry when the Nurse would not let her/him go outside alone. Per review of the letter that Resident #1 said had been hung up at the nurses station, it specified three Licensed Nursing Assistants (LNAs) by name who should not provide personal care, and one LNA who should not go in Resident #1's	F 550	**Tag F 550 POC accepted on 6/7/24 by S. Freeman/P. Cota**	

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F 550	Continued From page 2	F 550		

room for any reason unless a true emergency. The note says that Resident #1 is independent in personal care once provided with a basin of water and fresh towels, s/he does not require an LNA to wash, or apply creams to her/his genitals. It further states that Resident #1 [name written] has completed her/his rehab plan of care and is independent and should not be allowed to pull the young girls/boys into her/his room insisting that they wash her/his genitals, stating that this is a behavior, not a personal care need. Finally, the note states that s/he also does not require an hour long shower; 20 minutes for a shower is more than adequate and should not be provided by the young LNAs whom s/he is targeting.

Per interview on 5/2/24 at approximately 1:30 PM with an Licensed Practical nurse (LPN) who was familiar with the care needs of Resident #1, the Resident is not hard to get along with if you just listen to her/his concerns. The LPN confirmed that the note that discussed Resident #1's personal information had been posted at the nurse's station, and pointed to an area that was visibly accessible to anyone standing at the station, including other residents and visitors. The LPN also stated s/he understands why the Resident would be upset about a note like that being posted.

Per record review, there were two occasions on 10/5/23 where it appears that the treatment by staff triggered emotions and subsequently behaviors, when other approaches could have prevented escalation. These resulted in police being contacted for the angered response of the resident when staff did not allow them to exercise their right to go outside and when staff refused to administer requested pain medication and

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F 550	Continued From page 3	F 550		

inappropriately outlined the work that would need to be done by nursing to give them their scheduled pain medication.

Per record review a nursing progress note written on 10/5/2023 states "This writer arrived at BHR for work at [6:45 PM] when [I] saw [Resident #1] wheeling [themselves] into the lobby. This writer approached the resident and asked [her/him] where [s/he] was going. The resident responded that [s/he] was leaving and going outside to be alone and not to follow [them]." The nurse documented that after s/he provided education to Resident #1 about concerns for their safety and why s/he could not be left alone unsupervised outside. Resident #1 became "verbally irate" towards staff. After speaking with a different staff member for a period of time the staff member was asked to leave as their shift had ended. At this time the resident became verbally aggressive again. The note states "This resident was given many chances to return to the floor with multiple different staff members, all of which [s/he] refused. At this time, this writer contacted the DON and was advised to call the local police and EMS (Emergency Medical Assistance). The resident continued to refuse the option to return to the floor and refused to be transported to the ER. At this time EMS and local police left the scene and this writer sat one on one with the resident in the lobby."

A nursing progress note written on 10/5/2023 states At [9:15 PM] the resident wheeled [her/himself] into the elevator and returned back to the 3rd floor." At approximately 9:35 PM the Resident demanded their pain medication and the nurse said that the Resident could no longer receive her/his scheduled 8:00 PM dose because

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F 550	Continued From page 4 it was outside the one hour window and that the doctor would have to be contacted to have the time changed. The note states that the resident began verbally assaulting the staff and demanded the Nurse give [her/his] pain medication now. Resident #1 escalated and the Nurse called the local police at [9:39 PM]. The Nurse was advised by the Administrator to have the resident removed from the facility as [s/he] was continuing to verbally and physically assault staff. When the police arrived at the facility the resident refused to leave. At this time a decision was made by the administrator, police officer and staff that [Resident #1] could remain here but if [s/he] were to become escalated with staff again the police would come remove [her/him] from the facility immediately. During an interview on 5/2/24 at 1:35 PM the DON confirmed that Resident #1 became aggressive on 10/5/23 when the Nurse had told her/him that s/he could not go outside alone and s/he had called the police. Staff had been instructed to do so if Resident #1 became aggressive.	F 550		