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

July 31, 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 **July 5, 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 07/05/2024

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

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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite complaint investigation of intakes #22877, #22956, #22902, and #22906 on 6/25/24- 7/5/2024 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. There were regulatory violations identified as a result of the investigations.	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 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to monitor weights and verify potential significant weight loss and gains as needed for 5	F 692	F692 Specific Corrective Action 1. Resident # 2, 3, 4, 5, and 6 weights are being monitored to verify potential significant weight loss or gains and that reweighs are completed for any body weight not expected. 2. An audit of resident records was completed to validate that weights are obtained per MD order and if a resident body weight is not as expected, then a re-weigh was completed. This includes validation that anyone with a significant weight loss or gain of 5% in one month or 10% in 6 months had notification of this change to the Provider, Registered Dietician, and responsible party for further recommendations. 3. The facility obtains resident weights per the MD order. If the body weight is not as expected, then the resident is reweighed. The resident with significant weight loss/gain of 5% in one month or 10% in 6 months will have notification to the provider, RD, and responsible party for further recommendations. Licensed nurses will be re-educated to this process.	

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

CNHA — Administrator — 7/30/24

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 692	Continued From page 1 of 6 residents sampled (Residents #2, #3, #4, #5, and #6). Findings include: 1. Per record review Resident #2 has a Physicians order for monthly weights. Review of the Resident's Weight Summary revealed significant weight changes of 12.60% weight loss over one month and 10.82% over six months. On 1/3/24 the Resident's weight was documented as 245 lbs. one month later, on 2/3/24 the weight was documented as 256.0 lbs., an 11 lb. weight gain. There is no evidence that the resident was reweighed. On 5/15/24 the Resident's weight was documented as 250 lbs., on 6/3/24 the weight was documented as 218.5 lbs., a 31.5 lb. weight loss. There is no documentation that reweighs were obtained. 2. Per record review Resident #3 had documented significant weight loss of 6.72% over one month and 10.39% loss over six months. Review of the Resident's Weight Summary reveals that on 1/16/24 the Resident weighed 139.5 lbs., on 5/15/24 the Resident weighed 134 lbs., and on 6/19/24 the Resident's weight was 125 lbs., a 9 lb. weight loss over one month and 14.5 lb. weight loss. There were no documented reweighs in the record. 3. Per record review Resident #4 was admitted to the facility on 5/29/24. Review of Resident #4's care plan reveals that they are at risk for unplanned weight changes with a goal of "maintain weight within +/- 5 pounds [for] 90 days." Review of Resident #4's weight record for	F 692	F692 continued.. 4. DON/Designee will complete an audit of resident weight records to validate the process for reweighing and notification of significant weight loss/ gain is followed. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee f or further review and recommendations. Date of Compliance 8/6/2024 **Tag F 692 POC accepted on 7/30/24 by S. Freeman/P. Cota**	

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F 692	Continued From page 2 5/30/24- 6/28/24 reveals that daily weights were not obtained on 8 of the 30 days. Further review also revealed that Resident #4 had significant fluctuations in weight with no documented reweight. On 6/3/2024 the Resident's weight was documented as 408.5 Lbs. On 6/4/2024 the Resident's weight was documented as 368.4 Lbs., a 40.1 lb. discrepancy. On 6/9/24 their weight was documented as 372.0 Lbs., and on 6/10/2024 it was documented as 379.3 Lbs., a 7.3 lb. weight gain in one day. On 6/19/24 their weight was 370.2 lbs., and on and 6/21/2024 358.0 lbs. indicating a 22 lb. weight loss. There was no documentation that Resident #4 was reweighed on any of the following dates to rule out changes in clinical status or verify if it was an accurate weight. 4. Per record review Resident #5 has a Physicians Order for monthly weights. Review of the Resident's Weight Summary reveals a significant weight gain over one month. On 6/3/24 the Resident's weight was documented as 302.7 lbs., and on 7/1/24 their weight was 319.4 lbs., indicating a 16.7 lb. weight increase which is a 5.52 % gain. There is no documented evidence that the Resident was reweighed to ensure accurate weights and rule out a clinical change in health status. 5. Per record review Resident #6's weight record shows that Resident #6's monthly weights from 1/8/2024 - 6/18/2024 identified a gradual weight	F 692		

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F 692	Continued From page 3	F 692		

loss of 11 lbs. On 6/18/2024 Resident #6 was weighed using a mechanical lift, their weight was documented as 203.2 lbs.

On 7/1/2024 Resident #6 was weighed using a mechanical lift and their weight was documented as 194.8 lbs., an 8.4 lb. (4.13 %) weight loss in one month. There was no documented evidence that Resident #6 was reweighed to rule out a clinical change in condition or ensure the results were accurate.

Per review of the facility procedure titled "Weights and Heights"
Section 1. "Obtaining and Documenting Weight:
1.1.4 If the body weight is not as expected, re-weigh the patient."
Section 1.2
1.2.1 The Weights Exception Report will be reviewed by a licensed nurse with follow-up as indicated.
Section 2. Significant Weight Change Management:
2.1 Significant weight changes will be reviewed by the licensed nurse for assessment.
2.1.1 Significant weight change is defined as:
2.1.1.1 5% in one month
2.1.1.2 10% in six months
2.2 The licensed nurse will:
2.2.1 Notify the physician/APP and Dietician of significant weight changes;
2.2.2 Document notification of physician/APP and Dietician in the PCC [Point Click Care] Weight Change Progress Note.
2.3 The licensed nurse will notify the:
2.3.1 Physician/APP of the Dietician recommendation;
2.3.2 Patient representative of the weight

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F 692	Continued From page 4 change and Dietician recommendations. Notification will be documented. Per interview with the Dietitian on 7/2/24 at 2:16 PM when a resident is weighed and there is a significant discrepancy from the previous documented weight, they should be reweighed to determine accuracy of the weight. The Physician and Dietitan should be notified if the weight discrepancy is found to be accurate. The Dietician confirmed that the facility policy was not consistently being followed. During an interview on 7/3/24 at 1:20 PM The Director of Nursing (DON) stated that if there was an identified discrepancy when weighing a resident staff should reweigh them to verify the change. The DON confirmed that the facility policy was not followed, and that documented reweighs were not available for review in the record.	F 692		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure that pain management was consistent with professional standards of practice and the comprehensive person-centered care plan was followed for 1 of 3 residents in the sample (Resident #1) as evidenced by a lack of	F 697	F697 Specific Corrective Action 1. Resident #1 is currently receiving ordered pain medication. Staff are monitoring for the presence of pain and the effectiveness of administered pain medication. This includes monitoring for any adverse drug reactions. 2. An audit of resident records was completed to validate those residents receiving pain medication had monitoring by staff for the presence of pain and the effectiveness of pain medication.	

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F 697	Continued From page 5 documentation for monitoring of the presence of pain and evaluating the effectiveness of regularly scheduled pain medication. Findings include: Per record review Resident #1 has diagnoses that include chronic pain syndrome, opioid dependence, opioid use disorder /substance abuse disorder (OUD/SUD), and arthritis. Per review of physician's orders Resident #1 has been receiving opioid medications for pain control since admission. A Physician's order dated 6/25/24 states "Buprenorphine HCl Sublingual [under the tongue] Tablet Sublingual 8 MG (Buprenorphine HCl) Give 1 tablet sublingually every 12 hours for pain." Another Physician's order dated 6/26/24 states "Buprenorphine HCl Sublingual [under the tongue] Tablet Sublingual 2 MG (Buprenorphine HCl) Give 3 tablet sublingually two times a day for pain for 28 Days..." The resident was receiving the pain medication on a routine basis; however, the record does not reflect consistent pain monitoring or the resident's response to the administration of the pain medication. A care plan focus initiated on 8/2/2023 related to verbal and physical behaviors lists an intervention of "Attempt non-pharmacologic interventions to alleviate pain and document effectiveness. Administer pain medication as ordered and document effectiveness/side effects." Another care plan focus states that Resident #1 "exhibits or is at risk for alterations in comfort related to chronic pain and history of opiate dependency [and] chronic [right] shoulder pain." Listed interventions include "Evaluate pain characteristics: quality, severity, location, precipitating/relieving factors, Utilize pain scale,	F 697	F697 continued... 3. The facility ensures that residents receiving opioids are monitored for effectiveness and any adverse drug reactions. Residents will be evaluated for the presence of pain, at a minimum daily, by making inquiries of the patient and/or by observation of signs and symptoms of pain. Licensed nurses will be re-educated to this process. 4. DON/Designee will audit resident records to validate that residents receiving pain medication have documentation of the monitoring and effectiveness of pain medication. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 8/6/2024 **Tag F 697 POC accepted on 7/30/24 by S. Freeman/P. Cota**	

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F 697	Continued From page 6 Medicate [resident] as ordered for pain and monitor for effectiveness and monitor for side effects, report to physician as indicated." Review of Resident #1's documented Pain Level Summary for the months of April, May, and June 2024 revealed that a numeric pain rating was documented 3 of 30 days in April. There were 6 documented numeric pain ratings in May. Per facility policy titled NSG227 Pain Management, Section 2.1 "When opioids are used, the lowest possible effective dosage should be prescribed for the shortest amount of time possible after considering all medical needs. the patient should be monitored for effectiveness and any adverse drug reactions. Section 5. states "At a minimum of daily, patients will be evaluated for the presence of pain by making an inquiry of the patient or observing for signs of pain. Section 9. Patients receiving interventions for pain will be monitored for the effectiveness and/or side effects/adverse reactions (...) Document: 9.3 Ineffectiveness of routine or PRN [as needed] medications including interventions, follow-up, and physician... notification; Per interview on 7/3/24 at 1:20 PM, the Director of Nursing confirmed that there was no regular pain monitoring or evaluation for effectiveness performed for Resident #1.	F 697		
F 741 SS=D	Sufficient/Competent Staff-Behav Health Needs	F 741		

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F 741	Continued From page 7 CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review the facility failed to ensure that staff was provided the necessary training and possessed the necessary competencies to care for residents with diagnoses of OUD (opioid use disorder), SUD (substance abuse disorder), and PTSD (post-traumatic stress disorder) for 1 of 7	F 741	F741 Specific Corrective Action 1. The LNAs and the licensed nurse identified had training completed on OUD (opioid use disorder), SUD (substance abuse disorder), and PTSD (post-traumatic stress disorder) and trauma-informed care. 2. An audit of staff records was completed to validate that nursing staff have been provided the necessary training and possesses the necessary competencies to care for residents with diagnoses of OUD (opioid use disorder), SUD (substance abuse disorder), and PTSD (post-traumatic stress disorder), inclusive of trauma-informed care education. 3. The facility ensures staff have been provided the necessary training and possess the necessary competencies to care for residents with diagnoses of OUD (opioid use disorder), SUD (substance abuse disorder), and PTSD (post-traumatic stress disorder), inclusive of trauma-informed care education. The nurse leadership team, inclusive of the nurse educator, will be re-educated to this process 4. NHA/Designee will audit staff education records to validate the necessary training and competencies to care for residents with diagnoses of OUD (opioid use disorder), SUD (substance abuse disorder), and PTSD (post-traumatic stress disorder), inclusive of trauma- informed care education have been completed. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 8/6/2024	

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F 741	Continued From page 8 sampled residents (Resident #1). Findings include: Per review of 3 Licensed Nursing Assistant's (LNA's) employee training files. 2 of the 3 LNAs had not received any training related to OUD or SUD. 1 of 3 LNAs files revealed no evidence of training related to PTSD and trauma informed care. Per review of 3 Staff Nurse employee files, 1 Registered Nurse (RN) file revealed no evidence of training related to SUD, OUD, PTSD, and trauma informed care. Per interview with the Registered Nurse assigned to Resident #1 on 7/3/24 at 8:35 AM S/he was recently hired on 7/3/24. The RN confirmed that S/he had not received resident specific training regarding SUD, OUD, PTSD, and trauma informed care since being hired. When asked if S/he knew of any residents on her/his assignment who had a diagnosis of SUD, OUD, or trauma, the RN stated that they did not know of any residents with those diagnoses.	F 741	**Tag F 741 POC accepted on 7/30/24 by S. Freeman/P. Cota**	