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

November 18, 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 recertification survey conducted on **October 23, 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, BS
Assistant Division Director
State Survey Agency Director

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 10/23/2024

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

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E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 10/23/24. There were no regulatory violations identified.	E 000	The filing of this plan of correction does not constitute any admissions as to any of the alleged violations set forth in this statement of deficiencies. The plan of correction is being filed as evidence of the facility's continued compliance with all applicable laws and the facility's desire to continue to provide quality services.	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and 6 complaint investigations (Intake #23282, #22998, #22918, #22916, #23114, and #23303) from 10/21/24 through 10/23/24 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following deficiencies were identified:	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580	1. Resident #104 was treated for a change in condition and resident's representative has been made aware. The resident has suffered no adverse outcome as a result of this alleged deficient practice. 2. Any resident with an assigned Representative who experiences a wound deterioration and/or a change in mental status and sent to the hospital has the potential to be affected by this alleged deficient practice. 3. Nurses will be educated on the requirement that resident representatives be notified of any resident change in condition. 4. Weekly audits will be conducted to ensure that resident representatives have been notified of any change in condition. These audits will begin on November 13, 2024 and will continue weekly x4 and then monthly for 90 days or until substantial compliance is achieved. Audit results will be reported to the facility QAPI committee. 5. The DON/designee is responsible for this plan of correction	11/13/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
LNHA	Administrator	11/14/24

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 580	Continued From page 1 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify a Resident Representative of a change in condition related to a worsening wound, abnormal laboratory results, and transfer to the hospital. Findings include: Per interview on 10/23/2024 at 9:35 AM Resident #104's Representative stated that s/he had not been notified by the facility that Resident #104's	F 580	**Tag F 580 POC accepted on 11/15/24 by S. Freeman/P. Cota**	

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F 580	Continued From page 2 wound had worsened. The Representative also stated that s/he had not been notified by the facility that the Resident's blood work was abnormal, and that the Resident had been transferred to the hospital. Per record review Resident #104 was admitted to the facility in September 2024 with a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an open/ruptured serum-filled blister) on his/her coccyx and venous stasis ulcers. A care plan focus for Advanced Directives states "Inform resident/patient and/or healthcare decision maker of any change in status or care needs." A skin assessment was completed on 9/8/23 reveals a wound measuring: 1. Area 0.4 cm2 2. Length 1.4 cm 3. Width 0.5 cm 4. Depth 0.2 cm 5. Undermining Not Applicable 6. Tunneling Not Applicable On 9/18/23 the wound measured" 1. Area 1.9 cm2 2. Length 2.0 cm 3. Width 1.3 cm 4. Depth Not Applicable 5. Undermining Not Applicable 6. Tunneling 0.3 cm Review of the Nurse Practitioner progress note dated 9/17/2024 stated the wound had progressed to a stage 3 pressure ulcer (Full-thickness skin loss with damage to subcutaneous tissue extending down to (but not	F 580		

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F 580	Continued From page 3 including) the underlying fascia (connective tissue)). There is no documented evidence that the Resident #104's Representative was notified of the worsening wound. Review of progress notes dated 9/24/23, Resident #104 was noted to be lethargic and "seems different than usual." The Physician was notified and the nurse received orders for blood work. The Resident's Representative was notified of the Resident's condition and the order for blood work. Upon receiving the results of the blood work Resident #104 was sent to the Emergency department for treatment. Per the hospital Emergency Report the Resident had a "markedly elevated sodium level." There is no documented evidence that the facility notified the Resident's Representative of the elevated sodium level, or the need to transfer the Resident to the hospital. During interview on 10/23/2024 at approximately 2:15 PM the Assistant Director of Nursing confirmed that there was no documented evidence that the Representative was notified of the worsening wound, the results of the blood work, or the transfer to the hospital. *https://learning.lww.com/files/BacktotheBasicsWoundAssessmentManagementandDocumentation-1662480009184.pdf	F 580		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690	1. A urinary continence evaluation has been completed for residents #105, 31 and 48. There have been no adverse outcomes for these residents as a result of this alleged deficient practice. 2. Any new admission that has urinary incontinence has the potential to be impacted by this alleged deficient practice.	11/13/24

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F 690	Continued From page 4 admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess Residents for urinary and bowel incontinence on admission to ensure that a resident who is incontinent receives appropriate treatment and services to restore continence to the extent possible for 3 of 4	F 690	All current resident records have been audited to ensure completion of a urinary incontinence evaluation. 3. All nurses will be educated on the continence management policy. 4.Weekly audits of new admissions with incontinence will be conducted to ensure a Urinary Incontinence Evaluation is completed, the transient causes for incontinence are addressed and a Three Day Continence Diary is initiated where applicable. These audits will be initiated on November 13, 2024 and will be conducted weekly x4 weeks and then monthly for 90 days or until substantial compliance is met. Results of these audits will be reviewed by the facility QAPI committee. 5. The DON/designee is responsible for this plan of correction. **Tag F 690 POC accepted on 11/15/24 by S. Freeman/P. Cota**	

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F 690	Continued From page 5 Residents in the sample (Resident #31, #48, and #105). Findings include: Per record review Resident #105 was admitted in October 2024. A care plan focus and the Resident Kardex indicate that he/she is incontinent, interventions identified include 1 assist with perineal care as needed, multi-void disposable briefs to contain incontinence. Another care plan focus reflects that Resident #105 "is incontinent of urine and is unable to cognitively or physically participate in a retraining program due to Dementia." There is no documented evidence of a urinary or bowel continence assessment in the record. Per interview on 10/22/2024 at 2:45 PM a Licensed Nursing Assistant (LNA) stated that on admission, staff were told that Resident #105 was continent of urine however, he/she was not. The LNA stated that staff check the Resident's brief "about every two hours" and s/he did not know if there was a specific schedule when to do so. The LNA said that he/she would have to check the Resident's care plan to know if there was a schedule. Review of Resident #105's toileting documentation shows several hour gaps, between toileting assistance. Examples of these gaps include 10/18/24, when staff documented that the Resident was toileted at 9:47 AM and then not until 10:11 PM; on 10/20/24, when staff documented that the Resident was toileted at 8:42 AM then not until 7:56 PM; and on 10/22/24 when staff documented that the Resident was toileted at 12:13 AM and then not until 1:23 PM. Per facility Continence Management policy, if the	F 690		

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F 690	Continued From page 6 Resident is incontinent upon admission, complete a Urinary Incontinence Evaluation, address the transient causes for incontinence and initiate the Three Day Continence Management Diary. Per interview with the Unit Manager (UM) on 10/23/2024 at 11:30 am residents are evaluated for bowel and bladder continence on admission using the "Nursing V 11 Admission Assessment". During the interview the UM accessed Resident #105's Admission Assessment; the urinary continence evaluation had not been completed. The Admission Assessments for Residents #31 and #48 were also reviewed with the UM revealing that their urinary continence evaluations were also not completed. The UM confirmed that Residents #105, #31, and #48 had not been assessed for continence on admission, and that the facility policy had not been followed.	F 690		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents'	F 726	1. No resident experienced an adverse outcome as a result of this alleged deficient practice. 2. Any resident receiving care from an LNA who has not had proper competency evaluation has the potential to be affected by this alleged deficient practice. 3. Nursing management staff was provided education that the facility must ensure that LNAs receive general competency and skills training for their position upon hire, annually and at other times as determined by the facility leadership in accordance with the facility assessment.	11/13/24

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F 726	Continued From page 7 needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, staff education record review, and the facility assessment, the facility failed to ensure that 4 of 5 sampled licensed nursing assistants (LNAs) were assessed for competency and skill sets needed to provide care and respond to each resident's individualized needs. This has the potential to affect all residents. This is a repeat deficiency. Findings include: The Facility Assessment (an assessment that determines what resources are necessary to care for the residents competently during both day-to-day operations and emergencies), dated 10/9/2024, reveals under section 1 titled "Resident Population," that "All staff receive general competency and skills training for their position upon hire, annually, and at other times as determined by the facility management." Per review of 5 LNA education records, 4 of the 5 sampled LNAs currently working at the facility did not have documentation of the competency	F 726	4. The LNAs identified had the required competencies completed. All LNA files have been audited to ensure that compliance with required competency validation is complete. Weekly audits will be conducted to ensure that LNA staff have documented competencies upon hire and annually as per the facility assessment. These audits will commence on November 13, 2024 and will be completed weekly x 4 then for 90 days or until substantial compliance is achieved. Results of these audits will be reviewed by the facility QAPI committee. 5. DON/Designee is responsible for this plan of correction. **Tag F 726 POC accepted on 11/15/24 by S. Freeman/P. Cota**	

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F 726	Continued From page 8 evaluation required to demonstrate that they had the necessary skills to provide care needed. 3 of the 4 LNAs with hire dates of 9/30/22, 5/16/22, and 3/21/23, did not have annual competency evaluations, and 1 LNA with a hire date of 10/6/24, did not have a competency evaluation upon hire. Per interview on 10/23/24 at 11:35 AM, the Professional Development Coordinator confirmed that the above 4 LNAs did not have competency evaluations completed required to care for the residents.	F 726		