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 3, 2022

Mr. J. Michael Rivers, Administrator
Center For Living & Rehabilitation
160 Hospital Drive
Bennington, VT 05201-2279

Dear Mr. Rivers:

Enclosed is a copy of your acceptable plans of correction for the investigation conducted on **April 25, 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,

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
	475029	A. BUILDING _____ B. WING _____	R-C 04/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER FOR LIVING & REHABILITATION	160 HOSPITAL DRIVE 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 onsite revisit to the 02/16/22 recertification survey was completed by the Division of Licensing and Protection on 4/25/2022. While the facility was found to be in substantial compliance, the following issue was identified that requires a plan of correction.	F 000		
{F 656} SS=B	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	{F 656}	**F 656** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* The orders and care plan for Resident #67 was reviewed and updated as indicated for the care of his portacath. *2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* An audit of all residents (including their orders and care plans) was conducted to identify those with invasive treatments. No concerns were noted. *3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?* The following policies were reviewed and updated as indicated: "Admission of the Resident", "Resident/Patient Admission Assessment", "Colostomy Care",	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mike Rivers — TITLE: Administrator — (X6) DATE: 5/2/22

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 656}	Continued From page 1 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document 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 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to implement care plan interventions for 1 of 6 sampled residents. (Resident #67). Findings include: Per review of Resident #67's Activities of Daily Living Care Plan, the resident is identified as having a "Portacath", (an implantable venous access catheter). Care Plan interventions initiated on 11/18/2021 include "Access and manage per protocol." On 2/16/2022 an intervention was added "[Resident] has a Porta Cath. This is to be flushed every morning shift. If patient declines or refuses flushes to [his/her] Porta Cath please document the refusal and report to the MD." Per review of Res. #67's Medication and Treatment records there is no documentation that the Portacath was accessed and managed per the resident's Care Plan since the intervention was added to the Resident's Care Plan. Per interview with the Director of Nursing [DON] on 4/25/22 at approximately 3:45 PM, the DON confirmed that there was no documented	{F 656}	"Dialysis Catheter Site Monitoring", "Dialysis Shunt Site Monitoring", "Gastrostomy Tube and Jejunostomy Tube Care", "Implantable Venous Access Device", "Indwelling Foley Catheter Procedure", "IV Insertion and Termination", "IV Saline Well Flush Procedure", "Nephrostomy Catheter Care", "Oxygen Administration", "Percutaneous Drainage Catheter", "Pleurix Catheter", "PICC/Midline Maintenance, Termination and Troubleshooting", and "Urostomy Care". Order templates were created for the care and management of portacaths, peripheral IV's, dialysis access sites, urinary catheters, and oxygen therapy. The admission process was updated to include a review of the patient/resident assessment within 72 hours of admission/readmission to identify any invasive treatments in use. Education was provided to all RN's regarding patient assessment, identification, and care planning of invasive treatments. *4. How will the corrective actions will be monitored to ensure the deficient practice will not recur (ie: what quality assurance program will be put into place)?* For the next four weeks, the DNS and/or designee will conduct weekly audits of the admission assessment reviews for all	

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{F 656}	Continued From page 2 evidence that Resident #67's Portacath was accessed, flushed, or refused per the Resident's Care Plan.	{F 656}	admissions and of the orders and care plans for those patients/residents with invasive treatments. After four weeks, random audits of the admission assessments, orders and care plans will be conducted monthly for three months and then randomly thereafter. Findings will be reported to the RN Unit Managers as indicated. Results of the audit will be reported to the facility Safety-Quality Committee. *5. The dates corrective action will be completed.* May 7, 2022 **TAG F 656 POC Accepted on 05/02/22 S. Freeman/P. Cota**	