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

October 26, 2023

Ms. Meaghan Mosso, Administrator
Center For Living & Rehabilitation
160 Hospital Drive
Bennington, VT 05201-2279

Dear Ms. Mosso:

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

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
	475029	A. BUILDING _____ B. WING _____	C 09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER FOR LIVING & REHABILITATION	160 HOSPITAL DRIVE BENNINGTON, VT 05201

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F 000	INITIAL COMMENTS An unannounced onsite investigation was conducted by the Division of Licensing and Protection for complaint #22140 and #22132 at the Centers for Living and Rehabilitation on 9/25/23 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory violations were identified:	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that 1 of 4 residents (Resident #3) in the applicable sample were treated with dignity and respect related to refusal of care. Per record review Resident #3 is frequently resistive and combative, which includes fighting, yelling, screaming, punching, pinching, and kicking staff during episodes of care. Review of nursing progress notes reveals that staff continue to provide care to Resident #3 even when s/he is resisting and refusing care. A care plan focus initiated on 2/11/21 states that	F 557	F 557 Respect, Dignity/Right to have Prsnl Property 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? An evaluation of the behavior patterns of Resident #3 was conducted and appropriate interventions were initiated. It was noted that the resident was more likely to resist care when fatigued and/or awakened from sleep. 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 was conducted to identify all residents who have a documented history of resistance to care. Their care plans were reviewed and updated as indicated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Meaghan T Mann | TITLE: Administrator | (X6) DATE: 10/23/23

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 557	Continued From page 1 the resident is "at risk for a behavior problem r/t severe agitation history secondary to Alzheimer's and bipolar disease. [S/He] does threaten to bite staff at times ... Can be combative with care..." There are no specific interventions for staff to implement related to combativeness with care. A fall risk care plan focus revised on 6/15/23 does reflect an intervention of "If [name omitted] is being resistive and or combative with care please make sure [s/he] is safe and leave the room and re approach [him/her]." Review of Progress Notes reveals that staff continued to assist the resident while S/he was combative and resistive to care after these care plan interventions were implemented. A progress note written on 9/14/23 states "resident combative with [Licensed Nurse Assistant (LNA)], punching, pinching, and trying to kick, resident doesn't want to be awake this early, 2 employees for care must be recommended at all times for safety reasons ..." A progress note written on 9/15/23 reflects that Resident #3 was "able to make needs known, very difficult to provide care and give personal care, resident was very aggressive, fighting, yelling, screaming, and resistive to all cares. Safety maintained during all the turmoil, meds given and taken, resident resting in bed voiced no complaints." On 9/23/23 a Health Status Note reveals "resident was being combative with care and [s/he] scratched [her/his] hand trying to combat the aids giving [her/him] care. There is a slight scratch and it only bled for a minutes. Just cleaned it and left it open to air." Per interview on 9/25/23 at approximately 4:15 PM with three Licensed Nurse Assistants (LNA) Resident #3 often does not want to receive care. They are unaware of any reason other than s/he just doesn't like it. The LNAs confirmed that the	F 557	3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The following policies were reviewed and updated as indicated: "Abuse, Neglect, and Exploitation", and "Dementia and Memory Impairment Care". Education was provided to all nursing staff regarding resistance to care and resident rights and approach with resistance to care. 4. How will the corrective actions 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 random audits/observations of staff approach during care. After four weeks, random audits/observations will be conducted monthly for three months and then randomly thereafter. Results of the interviews will be reported to the facility Safety-Quality Committee. 5. The dates corrective action will be completed. October 23, 2023	

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F 557	Continued From page 2 resident will hit, kick, and yell out during care and that staff continue to provide care even when the Resident is resistive and combative. During interview with the Director of Nursing (DON) on 9/25/23 at 4:45 PM the DON stated that s/he was not aware that Resident #3 was combative with care and that staff were providing care anyway. S/he also stated that staff have received education related to dementia care, difficult behaviors, and refusal of care. The above progress notes were reviewed with the DON and s/he confirmed that the resident has a right to refuse and that staff should not be forcing the resident to receive care.	F 557	**Tag F 557 POC accepted on 10/26/23 by S. Freeman/P. Cota**	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657	F 657 Care Plan Timing and Revision 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The care plan for Resident #1 was reviewed and updated as indicated. 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 resident care plans was conducted. Care plans were reviewed and updated as indicated.	

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F 657	Continued From page 3 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow a care plan and to revise a care plan for 1 out of 4 Residents sampled (Resident #1). Findings include: Per record review resident #1 has the following medical diagnoses, Alzheimer's Disease, bipolar disorder, and anxiety disorder. A progress note written on 8/5/23 reflects that after lunch Resident #1 was the aggressor in a resident-to-resident altercation. Resident #1 was sitting in the lobby waiting for his/her spouse to arrive. Staff who were assisting another resident witnessed Resident #1 strike another resident. Staff then intervened and redirected them from each other. A current care plan revised on 6/30/2023 reveals that Resident #1 has a behavior problem and requires 1:1 when out of room. The care plan includes the following interventions: 1) Direct monitoring (1:1) when out of room; 2) Deer Oaks (psychiatric services) consult; 3) Avoid lobby prior to meals ... Resident #1's August 2023 Medication Administration Record (MAR) reflects an order with the start date of 7/5/23 that states "1:1 close monitoring an hour before meals and an hour after, document behaviors in health status note with meals." Nursing had initialed the MAR at	F 657	3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The following policies: "Plan of Care", "Interdisciplinary(IDT) Plan of Care (POC) Document", and " Care Plan Meeting" were reviewed and updated as indicated. Education was provided to all nurses and social workers regarding the process for review and updating of care plans. 4. How will the corrective actions 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 randoms audits of care plan updates. After four weeks, random audits will be conducted monthly for three months and then randomly thereafter. Results of the interviews will be reported to the facility Safety-Quality Committee. 5. The dates corrective action will be completed. October 23, 2023	

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F 657	Continued From page 4 8:00 AM, 12:00 PM, and 5:00 PM as completed throughout the start and end date. Per interview on 9/25/23 at 11:00 AM the facility Administrator (LNHA) stated Resident #1 had been on one-to-one supervision at the time of the 8/5/23 altercation due to a previous resident-to-resident incident. The LNHA confirmed that the staff member who had been assigned to supervise the resident was not doing so at the time and was not present to prevent or interve in the incident. During an interview on 9/25/23 at 3:00 PM the Social Worker confirmed that resident has not been seen by Deer Oaks for psychiatric Services per the plan of care. During interview on 9/25/23 at 3:30 PM Resident # 1 was sitting in his/her room in a recliner chair. The resident revealed that staff do not accompany him/her to his/her destinations, and they do not sit with him/her when out of their room as per the care plan. Resident #1 further indicated that she/he goes where s/he wants by him/herself. Per interview on 9/25/23 4:00 PM a Licensed Practical Nurse (LPN) stated that Resident #1 ambulates independently to the dining room and usually sits in the corner alone until trays are delivered. The LPN revealed that Resident #1 is not currently on one-to-one, and indicated that staff keep an eye on him/her when he/she is walking in the halls. A second LPN interviewed at 4:20 PM stated that Resident #1 is "no problem" and is not on one-to-one that he/she is aware of. Per interview with the Director of Nurses (DON)	F 657	**Tag F 657 POC accepted on 10/26/23 by S. Freeman/P. Cota**	

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F 657	Continued From page 5 at 5:40 PM Resident #1 is not currently on 1:1 monitoring. The DON confirmed that resident #1's care plan states that he/she should be on one-to-one and that the care plan should have been updated but was not. The DON also confirmed that Resident #1's care plan has an intervention for Deer Oaks services and these services have not been initiated for Resident #1.	F 657	F 740	
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on Observation, Interview, and Record review the facility failed to assess and provide mental health services for 2 of 4 residents sampled (Residents #1 and #2). Findings include: 1. Per record review on 08/05/23, Resident #1 was involved in a resident-to-resident altercation as the aggressor in the altercation. A review of the care plan revealed Resident #1 had an intervention in place for a consult with Social Services and psychiatric services as indicated for a behavior modification plan, and another intervention for Deer Oaks services (Mental Health Counseling service) for support.	F 740	Behavioral Health Services 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1: An order for Deer Oaks was obtained and visits were initiated. Resident #2: The Biopsychosocial assessment was completed. 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 was conducted to identify those with behavioral health referrals (orders). All orders had been addressed. An audit of all residents was conducted to ensure that a Biopsychosocial assessment had been conducted for all residents. Missing assessments were completed.	

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F 740	Continued From page 6 Upon further review, Resident #1 did not have a physician order for Deer Oaks services and there was no documentation found that Resident#1 had received these services. Per interview with the facility social worker on 9/25/23 at 1:00 PM, it would be expected that there would be a Physician order for Deer Oaks and then a referral would be made. Social Services confirms that Resident # 1 does not have an order for Deer Oaks and the services have not been initiated. Per interview on 9/25/23 5:40 PM with the Director of Nursing (DON), Resident #1 does have an intervention for Deer Oaks on his/her care plan, but Deer Oaks services have not been initiated for Resident #1. 2. Per record review, Resident #2 was a victim in a resident-to-resident altercation on 8/5/23. Resident #2's care plan reflects an intervention for Psychiatric/Psychogeriatric consult as indicated; however, there is no documentation supporting that resident #2 has had these services. Resident #2's care plan indicates that the resident has "ineffective coping skills secondary to PTSD" (Post Traumatic Stress Disorder, a mental health condition triggered by a terrifying event either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event (www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes)). The care plan also indicates in a separate problem Resident #2 "has a psychosocial well-being problem r/t history of suspected trauma, suspected PTSD".	F 740	3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The following policies were reviewed and updated as indicated: "Biopsychosocial Assessment" and "Behavioral Health Emergency Management". A Support Services Log was created to track outside services orders and implementation. Education was provided to social workers and nursing staff regarding Biopsychosocial assessments and the referral process for Deer Oaks and/or telepsych. services. 4. How will the corrective actions 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 a weekly audit of new admissions to ensure that Biopsychosocial assessments have been completed. After four weeks, random audits will be conducted monthly for three months and then randomly thereafter. The audit results will be reported to the facility Safety-Quality Committee.	

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F 740	Continued From page 7 Review of the Resident's Biopsychosocial/Trauma assessment reveals one assessment was completed on 8/18/22. Section K Brief Trauma questionnaire is incomplete. There is no documentation explaining why this section was not completed. There is no supporting documentation that any further trauma assessments have been done since Resident #2's admission. Review of facility policy Biopsychosocial Assessment Reassessment -CLR policy number 699 under section IV. Policy statement Guidelines: A." An individualized Biopsychosocial assessment will be completed on all new admissions to subacute and long-term care within 7 business days. "B." Reassessment will be completed at a minimum of a quarterly basis." Per interview on 9/25/23 5:40 PM the DON confirmed that according to Resident #2's care plan, he/she should have a Psychiatric/Psychogeriatric consult, and that Resident #2 has not received these services. DON confirms that resident #2 Biopsychosocial Assessment was not completed on admission, that the resident has had no further Biopsychosocial Assessment completed, and that the facility policy has not been followed.	F 740	Additionally, for the next 4 weeks, the Social Worker and/or designee will conduct a weekly audit of Referrals made to Deer Oaks. After 4 weeks, random audits will be conducted for 3 months and then randomly thereafter. Audit results will be reported to the facility Safety-Quality Committee. 5. The dates corrective action will be completed. October 23, 2023 **Tag F 740 POC accepted on 10/26/23 by S. Freeman/P. Cota**	