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

August 15, 2018

Ms. Suzanne Anair, Administrator
Centers For Living And Rehab
160 Hospital Drive
Bennington, VT 05201-2279

Dear Ms. Anair:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 18, 2018**. 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 _____	C 07/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR LIVING AND REHAB	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 on-site complaint investigation was conducted by the Division of Licensing and Protection between 7/17 and 7/18/18. There were regulatory findings.	F 000		
F 656 SS=D	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)- (A) The resident's goals for admission and desired outcomes.	F 656	**F 656** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* Resident #1 is no longer a resident. Resident #2's care plan has been reviewed and updated. *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?* 100% of the resident's care plans were reviewed. *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 facility policies: "Plan of Care", "Psychotropic Medication Use", "Resident/Patient Admission Assessment", "Oxygen Administration via Nasal Cannula", "Behavioral Health Emergency Management", and "Suicide	

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

Administrator 08072018

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 (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 staff interview and record review, the facility failed to assure that a care plan was developed for 1 of 5 residents, Resident #1, regarding behaviors and psychotropic medications usage and impaired breathing resulting in oxygen therapy, and failed to implement the plan of care for 1 of 5 residents, Resident #2, regarding supervision. Findings include: 1.) Resident #1 was admitted to the facility with diagnoses that included unspecified dementia with behaviors. Review of the medical record lists the resident as receiving Zoloft 25 mg (milligram) daily and Haldol 1 mg (a typical antipsychotic medication) every eight hours as needed for agitation. Review of the medical administration record provided evidence that the resident received Haldol 1 mg on 4/5, 4/6 and 4/9/18 secondary to agitation. Further diagnoses included Chronic Organic Pulmonary Disorder and Shortness of Breath with physician orders for oxygen at 2 liters per minute via nasal canula at hour of sleep. Per interview on 7/17/18 with Licensed Nursing	F 656	Ideation Prevention and/or Management of Harmful Behaviors" were reviewed. Education for all nurses was completed about any policy changes to include when and how to develop, update, and/or initiate a care plan. Education was completed with all staff regarding the definition/levels of supervision and the process for implementation and maintenance of supervision as provided by policy. *4. How will the corrective actions will be monitored to ensure the deficient practice will not recur (i.e.: what quality assurance program will be put into place)?* For the next four weeks, the DNS and/or Designee will conduct a weekly random chart audit to verify that residents' care plans are updated to incorporate the items identified in the IDT meeting, with monthly random chart audit for three months. The results will be reviewed by the facility Safety-Quality Committee. *5. The date's corrective action will be completed.* August 18, 2018 F656 POC accepted 8/14/18 BBartlett/mm	

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F 656	Continued From page 2 Assistant and Licensed Practical Nurse that frequently provided care for Resident #1, the resident used oxygen continuously via nasal canula, the resident would remove the canula and frequently needed it to be replaced. Confirmed by the Director of Nursing Services at 1:50 PM on 7/17/18, that the medical record did not provide evidence of care plans for oxygen therapy or psychotropic medication use. 2.) Resident #2 has diagnoses that include dementia with behavioral disturbance and has a history of agitated aggressive behaviors directed at staff and other residents. On May 9, 2018, Resident #2 wheeled his/her rolling walker up behind another resident, Resident #4, who had stopped at the nursing station to ask the nurse a question and kicked the him/her. At the time of the incident, the care plan dated 3/9/18 regarding altered mood pattern for Resident #2 stated that the resident was at risk for increased aggressive behaviors and resident to resident altercations related to dementia and psychiatric history including delusions and hallucinations. Interventions included that the resident is to be close observation and monitoring when out of room and further states close monitoring after daughter visit. Staff confirmed that the resident was being monitored every 15 minutes for safety checks at the time of the incident, but the facility failed to observe Resident #2 advancing toward Resident #4. At the time of the incident the nurse seated at the nursing station had an obstructed view of Resident #2. On May 28,2018, Resident #2 once again wheeled up behind Resident #4 while s/he was standing at the nursing station and kicked	F 656	**F 658** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* Resident #1 is no longer a resident. *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?* 100% of the resident's oxygen/respiratory therapy orders were reviewed. *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 facility policies: "Physician Orders", "Oxygen Administration via Nasal Cannula", and "MAR/TAR Guidelines for Use" were reviewed. Education for all nurses was completed about any policy changes to include when and how to contact the physician for new or updated orders. *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)?*	

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F 656	Continued From page 3 him/her. Care plan revision on 5/9/18 for Resident #2 states that the resident is to be under close supervision when out of room and monitored for behaviors. Interview with the Director of Nursing Services on 7/18/18 at 8:55 AM that the staff failed to follow the care plan and closely monitor the resident per care plan and supervise the Resident #2 to prevent the incidents from occurring.	F 656	For the next four weeks, the DNS and/or Designee will conduct a weekly random chart audit to verify that residents' oxygen use/requirements are compatible with current physician orders. Monthly random chart audits will be conducted for three months thereafter. The results will be reviewed by the facility Safety-Quality Committee.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to provide services as outlined by the physician orders for one resident in the applicable sample, Resident #1. Findings include: Resident #1 was admitted to the facility with diagnosis of pneumonia, Chronic Organic Pulmonary Disorder and Shortness of Breath. Record review on 7/17/18 presented that the physicians orders were for oxygen 2 liters per minute at HS (hour of sleep) and per interviews with the Licensed Nursing Assistant, Licensed Practical Nurse and the Registered Nurse, the resident was using oxygen continuous via nasal canula during his stay in the facility. The Director of Nurses confirmed at 1:50 PM that there is no evidence that the physician had changed the order or had been notified of the	F 658	*5. The dates corrective action will be completed.* August 18, 2018 F658 POC accepted 8/14/18 BBurkell RN/PMC **F 689** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* Resident #4 has maintained her usual routines. Resident #2's care plan has been 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?* 100% of the residents have been reviewed for behavioral interventions/indication for supervision. Care plans have been reviewed and updated as indicated.	

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F 658	Continued From page 4 continued oxygen usage. The physician interviewed at 3:50 PM on 7/17/18, confirmed that the order for the oxygen was for HS and that he had not been notified that the resident was using oxygen on a continuous basis. Reference: Based on standards of professional nursing practice, Lippincott Manual of Nursing Practice 19th edition, Wolters Kluwer Health/Lippincott Williams, page 17 Standards of Practice was deviated with failure to follow to physician orders.	F 658	*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 facility policies: "Suicidal Ideation Prevention and/or Management of Harmful Behaviors", "Behavioral Health Emergency Management", and "Plan of Care" have been reviewed and updated as indicated. Education has been provided to all staff who provide supervision to residents regarding the policy and the process for enhanced supervision to those with behavioral or safety concerns. *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 a weekly random observation audit to verify that residents on enhanced observation status are being followed as indicated, with monthly random audits to be conducted for three months thereafter. The results will be reviewed by the facility Safety-Quality Committee.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that each resident receives adequate supervision to prevent accidents, for 1 of 4 residents in the sample, Resident #2. Findings include: Review of the medical record for Resident #4 provided evidence that s/he had been kicked, without provocation, by Resident #2 on two separate occasions, May 9 and May 28, 2018 while s/he was standing at the nursing station. Resident #2 care plan states that the resident is to be under close supervision and closely	F 689		

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F 689	Continued From page 5 monitored for behaviors when out of room. Resident #2 was on 15-minute safety checks and the staff in the immediate vicinity was behind the nursing station, which has a gated half-door that is latched and raised barrier. Resident #2 had been seated on the other side of the nursing station and when Resident #4 approached the nursing station, Resident #2 wheeled up to him/her and kicked Resident #4 in the shin. The Director of Nursing Service confirmed at 8:59 AM on 7/18/18 that the measures for supervision was not effective for Resident #2 and s/he had not been adequately supervised. Refer also to F656.	F 689	*5. The dates corrective action will be completed.* August 18, 2018 F689 POC accepted 8/14/18 BBarteaux/PNC **F 757** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* Resident #1 is no longer a resident.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons	F 757	*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?* 100% of the residents with psychoactive medication orders were reviewed. *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 facility policies: "Psychotropic Medication Use", "MAR/TAR Guidelines for Use", and "Plan of Care" were reviewed. Education for all nurses was completed regarding any policy changes/updates. Education was provided to all nurses	

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F 757	Continued From page 6 stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that 1 resident in the applicable sample, Resident #1, drug regimen was free from unnecessary drugs. Findings include: Resident #1 was admitted to the facility with diagnoses that included unspecified dementia with behaviors, Chronic Organic Pulmonary Disorder and Shortness of Breath , pneumonia, glaucoma and throat cancer. Review of medical record lists the resident as receiving Haldol 1 mg (a typical antipsychotic medication) every eight hours as needed for agitation. Review of the medical administration record provided evidence that the resident received Haldol 1 mg on 4/5, 4/6 and 4/9/18 secondary to agitation. The physician confirmed at 3:45 PM on 7/17/18, that the Haldol had been ordered by another physician prior to admission to the facility and s/he continued the order for the resident when s/he was admitted to the nursing home. The Haldol was ordered February 2018 secondary to behaviors and s/he confirmed that there was no evidence of a supporting diagnosis to support the Haldol usage.	F 757	regarding diagnosis for medications, GDR process and care planning for non-pharmacological interventions for those requiring psychoactive medication use. *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 a weekly random chart audit to verify that psychoactive medication orders include diagnosis/indication for use. Monthly random chart audits will be conducted for three months thereafter. The results will be reviewed by the facility Safety-Quality Committee. *5. The dates corrective action will be completed.* August 18, 2018 F757 POC accepted 8/14/18 BBoutell RN/PMC	