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

January 3, 2019

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 **December 6, 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

Pamela M. Cota, RN
Licensing Chief

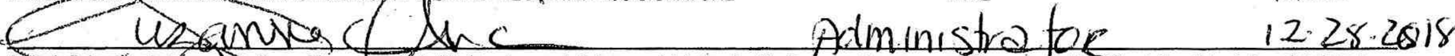
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 12/06/2018

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
E 000	Initial Comments An unannounced emergency preparedness review was conducted by the Division of Licensing and Protection during the re-certification survey between 12/3/18 and 12/6/18. There were no regulatory violations regarding emergency preparedness planning.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted a re-certification survey and an investigation of a facility reported incident between 12/3/18 and 12/6/18. The following regulatory violations were cited as a result.	F 000		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585	**F 585** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* No residents were identified. *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?* All residents with a grievance have the potential to be affected. *3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	12-28-2018



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 585	Continued From page 1 §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being	F 585	The policy: "Grievance Policy" was reviewed and updated. Education was provided to all staff regarding the updated policy and the procedure for assisting a resident with filing a grievance. Education was also provided to the members of Resident Council regarding the Grievance Officer and the process for filing a grievance. Additionally, residents were also provided education through meetings such as "Coffee and Conversations". Resident representatives were notified in writing of the updated policy information. *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 Grievance Officer and/or Designee will review the grievances filed and the identified resolutions to insure that the process is being followed. Monthly random chart audit to be conducted for three months thereafter. The results will be reviewed by the facility Safety-Quality Committee.	

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F 585	Continued From page 2 investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, the facility failed to include in the grievance policy all the required information pertaining to identifying a grievance official per CMS (Centers for Medicare Services) requirements. Findings include:	F 585	*5. The dates corrective action will be completed.* January 5, 2019 F585 POC accepted 1/2/19 BBorkell RN/PMC	

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F 585	Continued From page 3 During a review with residents on the resident council on 12/4/18, the residents in attendance stated that they did not know who the grievance official was and named different staff members that they thought might be the official. During a review of the grievance policy with the administrator at 3:34 PM on 12/4/18, s/he confirmed that as administrator s/he is the grievance officer and the policy does not reflect all the required contact information of the grievance officer, including the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number nor the right to obtain a written decision regarding the grievance.	F 585		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	F 623		

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F 623 Continued From page 4

(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State

F 623

F 623

1. *What corrective action will be accomplished for those residents found to have been affected by the deficient practice?*

Residents #233, 284, 340, 22, 23, 54, 56, and 83 were affected. All received care at acute care facilities, received indicated medical treatment, and returned to CLR. Two residents have since been discharged to home while the remainder continue to reside at the facility.

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?*

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623

Continued From page 5

Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to notify the resident and/or resident's

F 623

All residents who require a transfer out of the facility have the potential to be affected. An audit of all residents who were transferred from the facility in the past 30 days was completed to evaluate for notification of transfer and documentation of transfer. Of those who were transferred, all returned to the facility and 2 have been subsequently discharged.

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 transfer form has been updated and has been incorporated in the documentation system.

Education has been provided to all nursing staff, to social service staff and to administrative staff involved in the scheduling of transfers regarding the transfer form and process.

The policies: "Admission, Discharge, and Transfer Criteria", "Change in Resident's Condition or Status", and "Resident Rights" were reviewed and updated as indicated.

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F 623 Continued From page 6

representative in writing of a transfer/discharge; and send a copy of the notice to the Ombudsman (public official appointed to investigate complaints people make against government and/or public organizations) for 8 of 8 applicable residents in the sample (Residents #56, 233, 54, 22, 23, 83, 284 and 340). Findings include:

1.) Per record review Resident #56 was transferred to the hospital on 10/10/18 and had returned to the facility on 10/11/18. Per interview on 12/5/18 at 12:15 PM with the social worker, s/he confirmed that a transfer notice was not given to the resident and/or resident's representative.

2.) Per record review Resident #233 was sent to the Emergency Department on 11/30/18. Per interview with the social worker on 12/6/18 at 9:32 AM, s/he confirmed that a transfer notice was not given to the resident and/or resident's representative.

3.) Per review of the medical record, Resident #23 was sent to the Emergency Room and or was hospitalized the following dates; 4/15/18, 5/7/18, 8/26/18, 9/17/18, 11/30/18 and 12/4/18. Confirmation was made by the social worker on 12/5/18 at 4:03 PM that transfer notices had not been provided to the resident and/or the resident's representative for any of the transfers.

4.) Resident #284 was transferred to a geriatric psychiatric hospital on 10/29/18 for medication evaluation and treatment and then readmitted to the facility. S/he was hospitalized at the local acute care hospital for fever and systemic inflammatory response syndrome. There was no evidence of transfer notification and the social

F 623

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 ne next four weeks, the DNS and/or Designee will conduct a weekly random chart audit to verify that residents who are transferred out of the facility have been provided with a transfer notice and that a copy has also been provided to the representatives. Additionally, a random chart audit will be conducted to verify documentation that the notice has been provided. Thereafter a monthly random chart audit is to be conducted for three months. The results will be reviewed by the facility Safety-Quality Committee.

5. The dates corrective action will be completed.

January 5, 2019

F623 POC accepted 1/2/19 BBartell RN/PMC

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worker confirmed at 4:03 PM on 12/5/18 that the notification had not been given.

5.) Resident #22 was hospitalized at the local acute care hospital on two separate occasions, 12/14/17 and again on 9/27/18. The social worker confirmed at 4:03 PM on 12/5/18, that there was no evidence of a transfer notice being given to the resident and or the resident's representative for either transfers to the hospital.

6.) Resident #54 went to the hospital emergency room on 11/18/18 and the social worker confirmed that there was no transfer notice given to resident or legal representative.

7. Resident #340 was sent to the hospital emergency room on 11/2/18. On 12/6/18 at 9:50 AM, the social worker confirmed that a transfer notice had not been given to the resident or legal representative.

8. Resident #83 had two emergency transfers to a hospital on 9/7/18 and again on 9/20/18. On 12/6/18 at 9:50 AM, the social worker confirmed that a transfer notice had not been given to the resident or legal representative at either of these transfers.

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

F 623

<u>F 689</u>

1. *What corrective action will be accomplished for those residents found to have been affected by the deficient practice?*

Resident #27 was transferred to a psychiatric facility for evaluation and for medication management. She has been readmitted with improvements noted in her behaviors.

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?*

All residents who have aggressive behaviors are at risk to affected. An audit was conducted to identify residents with aggressive behaviors and their care plans were reviewed to evaluate the level of supervision needed.

F 689

3. *What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?*

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accidents.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to provide adequate supervision to one resident in the applicable sample, Resident #27, to prevent accidents. Findings include:

Review of the medical records for Resident #27 notes that s/he had been exhibiting aggressive and assaultive behaviors toward staff for several days prior to an altercation with another resident. Progress notes of 10/7/18 state that the resident was unable to be redirected after several attempts. It was also noted in the medical review that the resident had a diagnosis of advanced dementia with behavioral disturbance and major depressive disorder. His/her care plans note that the resident is combative with direct care staff and had the potential to be physically aggressive to others with a history to harm others. Progress note dated 10/21/18 states Resident #27 was noted to be in and out of other resident's rooms and some residents were noted to have increased agitation when Resident #27 was present. The resident was placed on 15-minute checks following an altercation with another resident 10/5/18 in which s/he pushed a chair toward the other resident. On 10/23/18, Resident #27 approached another resident in the common area and without provocation struck him/her.

Per interview with Licensed Nursing Assistant that was on duty the evening of the incident, s/he stated that Resident #27 had been entering other resident rooms and s/he was agitated and pushing curtains at the staff. Review of the 15-minute checks notes that the resident was in his/her room ten minutes prior to the incident and

F 689

The policies: "Suicide Ideation Prevention and/or Management of Harmful Behaviors" has been reviewed and/or updated.

Education has been provided to all CLR staff regarding supervision, the identification of harmful behaviors, and communication/documentation of interventions.

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 residents who demonstrate harmful behaviors have been provided with the appropriate level of supervision. 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.

January 5, 2019

F689 POC accepted 1/2/19 BBortellRN/pmw

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five minutes after the incident. The Director of Nursing on 12/6/18 at approximately 1:00 PM that Resident #27 was labile, and supervision was probably not adequate at the time of the incident on 10/23/18.

F 690 SS=D 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 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

F 689

F 690

F 690

1. *What corrective action will be accomplished for those residents found to have been affected by the deficient practice?*

Orders have been obtained for Resident #340 and for Resident #55 that include

the size and balloon size of the foley to be used for each 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?*

All residents who require the use of a foley catheter have the potential to be affected. An audit was conducted of all residents who have a catheter to insure that orders for catheter use include size, type, and balloon size.

3. *What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?*

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 12/06/2018

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 690 Continued From page 10

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 record review and staff interview, the facility failed to have physician-ordered parameters surrounding use of indwelling Foley catheter for 1 of 2 residents in the applicable sample (Resident # 340). Findings include:

1. Per record review, Resident #340 was admitted to the facility 11/2/18 with an indwelling Foley catheter in place. Despite efforts to discontinue use of the catheter with a trial voiding period, the indwelling catheter was reinserted on 11/15/18. There were no physician orders with parameters noted for either the admission use of the catheter or for the reinsertion on 11/15/18 that included the specifics of what size catheter, how much water to insert in the balloon, or how often to change the catheter. This was confirmed with the resident's physician on 12/5/18, as well as the Unit Manager at 4:15 PM on 12/5/18.

F 690 (Plan of Correction)

The policies: "Catheterization, Female Urinary" and "Catheterization, Male" have been reviewed and updated.

Catheter Placement Protocol was implemented – Algorithm was attached to the above policies.

Education was provided to all nurses regarding catheter orders and regarding the new protocol.

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 residents who require the use of a foley catheter have appropriate orders that include the size and parameters for use of the foley catheter. Monthly random chart audit to 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.

January 5, 2019

F690 POC accepted 1/2/19 BBortell RN/PMe

F 756 SS=D Drug Regimen Review, Report Irregular, Act On
CFR(s): 483.45(c)(1)(2)(4)(5)

§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the

F 756

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F 756

Continued From page 11

facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to act on a recommendation from the pharmacist for 1 of 5 residents in the applicable sample (Resident #45). Findings include:

Per record review Resident #45 had a Physician order dated 7/3/2018 for Abilify 1 mg (milligram) at bedtime for depression. The facility's consulting Pharmacist completed a pharmacy

F 756

F 756

1. *What corrective action will be accomplished for those residents found to have been affected by the deficient practice?*

The pharmacy recommendation for Resident #45 was reviewed by his physician and appropriate documentation was obtained.

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?*

All residents who have been reviewed by the pharmacist and received recommendations have the potential to be affected. An audit of all pharmacy recommendations for the past 60 days was completed to evaluate response to recommendations.

3. *What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR LIVING AND REHAB	**160 HOSPITAL DRIVE BENNINGTON, VT 05201**

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F 756	Continued From page 12 review on 9/4/2018, and made a recommendation for a dose reduction or alternative treatment due to an increased risk for falls associated with the use of Abilify. The resident has experienced falls on 8/2/2018 and 8/3/2018. On 9/6/2018 the Physician signed the recommendation indicating that s/he agreed to implement the recommendation. During an interview on 12/06/18 at 10:26 AM, the RN Unit Manager confirmed that there had not been a reduction in the Abilify or a change in treatment based on the Pharmacist's recommendation, and that there was no supporting documentation by the Physician as to why.	F 756	The policies: "Pharmacy Drug Regime Review" and "Psychotropic Medication Use" have been reviewed and/or updated. Education was provided to the Medical Director, Nurse Practitioner, and to nurses regarding follow up indicated for pharmacy drug regime reviews documentation. *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 residents whose medication regimes have been reviewed by the pharmacist with recommendations identified have received follow and appropriate documentation from the appropriate physician. Monthly random chart audit to 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.* January 5, 2019 F756 POC accepted 1/2/19 PBartell RN/PMC	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475029	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 12/6/2018
NAME OF PROVIDER OR SUPPLIER **CENTERS FOR LIVING AND REHAB**	STREET ADDRESS, CITY, STATE, ZIP CODE **160 HOSPITAL DRIVE BENNINGTON, VT**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 842	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475029	MULTIPLE CONSTRUCTION A. BUILDING: B. WING	DATE SURVEY COMPLETE: 12/6/2018
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 842	Continued From Page 1 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that medical records were complete and accurately documented for 1 of 25 residents in the sample, Resident #233. Findings include: Per review of the social work progress notes dated 11/30/18, Resident #233 was sent to the hospital for an evaluation. There was no evidence in the medical record regarding why and when the resident was sent to the hospital; and no documentation regarding when and what condition Resident #233 was in when s/he returned from the hospital. Per interview on 12/6/18 at 9:56 AM with the Unit Manager, s/he confirmed that the above information was not documented in Resident #233's medical record and should have been.