

Division of Licensing and Protection

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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

June 18, 2019

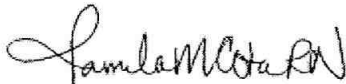
Ms. Suzanne Anair, Administrator
Centers For Living And Rehab
160 Hospital Drive
Bennington, VT 05201-2279

Dear Ms. Anair:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 14, 2019**. 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

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

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/14/2019
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NAME OF PROVIDER OR SUPPLIER CENTERS FOR LIVING AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 160 HOSPITAL DRIVE BENNINGTON, VT 05201
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(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
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F 000 INITIAL COMMENTS

F 000

The Division of Licensing and Protection conducted an unannounced on site complaint investigation on 5/14/19. The following regulatory violation was identified.

F 658 Services Provided Meet Professional Standards SS=D CFR(s): 483.21(b)(3)(i)

F 658

F 658

§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 upon interviews and record review, the facility failed to arrange for services according to accepted standards of practice for 1 of 2 residents, in the applicable sample, that needed to start oral chemotherapy. (Resident #1). Finding includes:

Per record review, Resident # 1 is being seen by an Oncologist (physician that treats people with cancer). The Oncologist ordered Temodar 140 mg oral capsule, one tablet daily, to be given while Resident #1 was undergoing radiation therapy treatment. (Temodar is an anti-cancer drug taken by mouth and is given during radiation therapy).

Per interview and confirmed with the Oncology Provider Nurse Practitioner (NP) on 5/14/19 at 12:00 noon, the NP saw Resident #1 at Centers for Living (CLR) on 5/2/19 for chemotherapy education and wrote a note in the medical record stating their office "will call CLR with the radiation schedule and when to begin Temodar". In

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

The oral chemotherapy medication for Resident #1 was ordered on 5/14/19 and obtained on 5/15/19 with administration initiated in conjunction with patient's radiation schedule as ordered.

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?

The progress notes and medication regimes of 100% of the residents with a cancer diagnosis were reviewed. 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 policies: "Transcription-Physician Orders", "Physician Orders", and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

Administrator

05/30/2019

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 658 Continued From page 1

addition, the NP stated the Oncology Provider Staff were in the process of assisting the resident's family to obtain the Temodar from an outside pharmacy and finding assistance to pay for the medication. Also stated the outside pharmacies could not fill the prescription as Resident #1 is a nursing home resident. The NP stated the Oncology Provider Staff were not aware that CLR could order Temodar from the facility's pharmacy and the medication could be received the next day at no charge to Resident #1. As of 5/14/19, the Temodar and Radiation Therapy had not been started.

Per interview and confirmed with the CLR Pharmacist on 5/15/19 at 11:45 AM, Temodar is in stock and available for Resident #1. The Pharmacist stated the Temodar would arrive at CLR the next day on 5/15/19 for Resident #1.

Per interview with the Medical Director and confirmed on 5/14/19 at 11:05 AM, the facility did not follow up with the Oncology Provider NP concerning his/her note written on 5/2/19 stating their office "will call with radiation schedule and when to begin Temodar".

Reference: Lippincott Manual of Nursing Practice 8th Edition, Wolters Kluwers Company; Lippincott Williams & Wilkins, pg 17 Standard of Practice was deviated with failure to follow-up with the Oncology Provider or NP re: chemotherapy treatment orders after the Oncology NP visit on 5/2/19.

F 658

"Physician Notification" were reviewed and updated as indicated.

Meet with Cancer Center representative to review communication procedures and continued use of red transfer packets for communication.

Education was provided to all nursing staff regarding specialty physician communication.

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 random chart audit of specialty physician progress notes to confirm that recommendations have been addressed. Random monthly reviews will be conducted thereafter for three months, then randomly as indicated.

5. The dates corrective action will be completed.

June 13, 2019

F658 POC accepted 6/17/19 Tammara RN/ML