

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury, VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

March 15, 2013

Ms. Wendy Beatty, Administrator  
Bennington Health & Rehab  
2 Blackberry Lane  
Bennington, VT 05201

Dear Ms. Beatty:

Enclosed is a copy of your acceptable plans of correction for the unannounced on-site recertification survey completed on **February 14, 2013**. 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

PC:jl



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

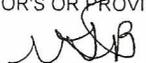
PRINTED: 03/01/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/14/2013
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NAME OF PROVIDER OR SUPPLIER  BENNINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2 BLACKBERRY LANE 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		
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on direct observation and staff interview, the facility failed to promote care for 2 residents in the Stage 2 sample of 24 (Resident #4 and #112) in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality. Findings include:</p> <p>1. Per direct observation on 2/11/2013 at approximately 3:00 PM at the 3rd floor nurses station, the surveyor observed, attached to the bulletin board a white piece of paper that stated, Resident #4 "is not allowed to smoke unless it's with [his/her] son. Do not expect this to change." The note was in full view of anyone who passed by or stood at the nurses station.</p> <p>Per interview with a facility Licensed Practical Nurse (LPN) on 2/14/13, he/she confirmed that Resident #4 was care planned to only smoke when his/her son is at the facility and able to take him/her. The LPN confirmed that the note behind</p>	F 241	<p><b>Plan of Correction</b> <b>F241</b></p> <p><b><u>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></b></p> <p>Resident #4 and resident #112 had no negative outcomes from this alleged deficient practice. The note was removed from the nurse's station.</p> <p><b><u>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:</u></b></p> <p>All residents have the potential to be affected by this alleged practice</p> <p><b><u>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:</u></b></p> <p>Staff will receive education regarding posting of personal information ,the use of plastic silverware and timely tray service. Extra silverware was ordered.</p> <p><b><u>4. How 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?</u></b></p> <p>Audits 3 x a week x 90 days to ensure there are no signs posted, that residents are not</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE EO	(X6) DATE 3.13.13
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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 241 Continued From page 1  
the nurses station contained personal information regarding Resident #4 and should not be in an area that can be viewed by other resident's or family members.

F 241

using plastic silverware and timely tray service is accomplished.  
Audit results will be reported to the center QI committee monthly x 90 days..  
DNS/Designee will be responsible for compliance.  
**5. Dates Corrective Action will be completed:**  
March 13 2013

*F241 PC accepted 3/13/13  
Mltigms RN/pmc*

2. Based on observation and interview, the facility failed to provide care in a manner that enhances each resident's dignity by not providing non-disposable flatware during the dining experience. During observation on 02/11/13 during the noon meal, residents at three tables furthest from the door in the 3rd floor dining room, were observed using plastic forks and knives. Per interview at that time the dietary aide stated "it just means we ran out of silverware". In addition, Resident #37 did not receive his meal tray for greater than 30 minutes after the

*web*

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F 241 Continued From page 2  
roommate's tray came. Resident #37, who is assessed as needing total assistance with feeding watched the roommate eat during this time. The roommate received the meal tray at 12:10 PM and Resident #37 received the meal tray and was fed at 12:45 PM. The Unit Manager, on 02/11/13 at 1:00 PM, confirmed the above findings.

F 241

F 248 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES

F 248

The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and record review, the facility failed to provide an ongoing program of activities designed to meet the interests and the physical, mental and psychosocial needs for well being for 2 of 24 residents of the stage 2 sample (Residents #148 and #105) and also other residents residing on the 3rd floor of the facility. Findings include:

1. Per interview on 2/11/13, Resident #148 indicated that he/she does not participate in the facility activities program and was not aware of what activities the facility has. Per direct observation from 2/11/13 through 2/14/13, Resident #148 was observed in his/her room in bed all day except for meals.

Per review of the comprehensive care plan, titled

**Plan of Correction**  
**F248**

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

Resident # 105 and #148 had no negative outcomes from the alleged deficient practice.  
Activity care plans were updated and hearing needs were documented .  
The activity director met with each of these residents.  
Resident #148 and# 105 now have a calendar of activities.  
Activity director is now assisting residents to select appropriate programs to attend.  
Resident 105 will be asked to consider an amplifier or audiologist consultation..

**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 have the potential to be affected by this alleged deficient practice.

*WJB*

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F 248 Continued From page 3  
"Activities", Resident #148 needs staff encouragement to attend out of room activities daily. Per interview with the facility Activities Director, he/she reviewed the activity logs for Resident #148 and confirmed that he/she had not attended facility activities outside of his/her room 9 out of 14 opportunities. The Activities Director reviewed the care plan and confirmed that the care plan indicated to encourage Resident #148 to attend out of room activities daily. The Activities Director also confirmed that there was no documentation that indicated that Resident #148 was offered activities and refused. The Activities Director confirmed that Resident #148 and the rest of the residents on the 3rd floor had not had activities on the unit on 2/13/13 and 2/14/13 because the Activities department did not have enough staff to conduct the planned activities on the 3rd floor.

2. Per record review, Resident #105 was admitted to the facility on 9/14/11, with diagnoses that include dementia and depressive disorder. Per interview with Resident #105 on 2/11/13, he/she indicated that he/she does not participate in the facility activity programs because "[he/she] can not hear so why bother." Resident #105 indicates he/she just stays in his/her room except for some meals.

Per direct observation from 2/11/13 through 2/14/13, Resident #105 was observed in his/her room in bed all day. Per review of the comprehensive care plan, there was no documentation regarding Resident #105's specific hearing needs and interventions that would assist Resident #105 with participating in out of room activities.

F 248

**3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:**

Activity staff will be re-educated on activity documentation and the need to follow care plan.  
Those residents that choose to stay in their rooms will have activity calendars in their room.  
Activity staff will review these calendars with each resident monthly to determine their activity likes and dislikes.  
In room activities will be provided for those residents who desire in room activities..

**4. How 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?**

Weekly audits of resident activity attendance and care plans x 90 days with audit results reported to the center QI committee monthly.

**5. Dates Corrective Action will be completed:**

Administrator/Designee will be responsible for compliance.

March 13, 2013  
F248 POC accepted 3/13/13  
Mlhqms RNF/PMC

*WJB*

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F 248 Continued From page 4

Per interview with the facility Activities Director, he/she reviewed the activity logs for Resident #105 and confirmed that Resident #105 had not attended facility activities outside of his/her room. The Activities Director confirmed that he/she was unaware that Resident #105 was failing to participate in out of room activities related to Resident #105's inability to hear. The Activities Director reviewed the care plan and confirmed that the care plan did not indicate any resident specific interventions to assist Resident #105 with activities that require the ability to hear. The Activities Director also confirmed that there was no documentation that indicated that Resident #105 was offered activities and refused. The Activities Director confirmed that Resident #105 had not received one to one visits per the care plan on 2/2, 2/3 and 2/11 because the Activities Department did not have enough staff to accommodate in room visits with residents.

F 279 SS=D 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and

F 248

F 279

**Plan of Correction**

**F279**

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

Resident #97 had no negative outcome from this alleged deficient practice.  
A care plan has been implemented for the skin issues and chronic ulcers.

**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:**

Residents with open skin areas have the potential to be affected by this alleged deficient practice..

*WJB*

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F 279 Continued From page 5  
psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:  
Based upon staff interview and record review, the facility failed to develop a comprehensive plan of care regarding chronic leg ulcers for one resident (Resident # 97) in the Stage 2 sample of 24. Findings include:

Per record review of Nursing Notes for Resident #97, on 9/16/11 "fax sent to MD giving update on current status of areas to Resident's right shin stasis ulcer" with "nursing monitoring area weekly." On 4/11/12 Nursing Notes record both of Resident #97's legs as "red and edematous" and four days later Nursing Notes report "multiple scabbed areas noted on left leg". On 7/5/12 Nursing Notes record "non pitting edema to bilateral ankles", and on 10/24/12 Resident #97 is documented as receiving ointment and dressings to both legs for "open sores that the resident continues to scratch at".

Per the facility's Comprehensive Review on 7/6/12 the resident has a "diagnosis of PVD [peripheral vascular disease]... has stasis ulcers to [h/her] lower legs ... [h/she] says the ulcers come and go". Per record review Nursing Notes on 1/6/13 report both lower legs "reddish purple from knee and ankle... warm to touch. Several open areas on legs" and the following day the

F 279

**3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur;**  
The care plan of all residents identified as at risk will be audited for appropriate care planning.  
Nursing staff will receive education on care planning for skin/ wound care.

**4. How 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?**  
Any new skin issues or wounds will be charted in the nurses note.  
The 24 hour report will be reviewed at morning meeting. Resident care plan will be audited for timely and appropriate documentation for wound and skin issues.  
Audits will be done 5 days per week x 30 then twice a monthly x 60 days .Audit results will be reported to the QI committee monthly.

**5. Dates Corrective Action will be completed:**  
March 13 2013  
DNS/Designee will be responsible for compliance.  
March 13 2013

F279 POC accepted 3/13/13  
Mitigating Risk POC

*WSB*

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F 279	Continued From page 6 resident is started on antibiotic treatment for cellulitis [inflammation of the cells] in h/her legs.  Per staff interview with the Charge Nurse on Resident #97's unit on 2/14/13 at 1:20 P.M. the Charge Nurse stated it was h/her expectation that due to Resident #97's diagnosis of PVD and the resident's recurring ulcers, a care plan for skin issues and impairment risks would be put in place but that there was none. Per record review and confirmed by the Charge nurse, there was no plan of care for skin issues on the resident's written chart, and per interview on 2/14/13 at 1:27 P.M. with the facility's Infection Control Nurse there is no active care plan on the facility's computerized care system regarding Resident #97's skin issues and chronic ulcers.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	<b><u>Plan of Correction</u></b> <b><u>F280</u></b> <b><u>I. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></b>  Resident #29 now has a MD order for the open areas on the buttocks. Pain medication is being offered prior to the treatment. The care plan has been updated to reflect the care to the open areas on the buttocks as well as the port for dialysis. Resident # 4 was not affected by this alleged deficient practice. The care plan has been revised to reflect interventions to prevent any inappropriate behaviors.	

*WSB*

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F 280 Continued From page 7

This REQUIREMENT is not met as evidenced by:

Based on observation, record review and interview the facility failed to revise the care plan for 2 of 24 residents in the Stage 2 sample (Resident #29 and #4). Findings include:

1. Resident #29's care plan was not revised to reflect the current status of the ports/fistula use and not revised to reflect care for a wound. Per interview on 02/11/13 at 3:58 P.M. Resident #29 indicated that s/he was having pain from the sore on the buttocks. Additionally, the resident indicated that s/he uses a port instead of a fistula for a certain treatment. Per observation of care at that time, 4 open areas and redness was noted on the resident's buttocks. Per interview with nursing staff on 02/12/13 at 2:24 P.M. stated that the resident did not have any pressure sores. Per record review on 02/13/13 of the current care plan, staff were directed "to monitor [fistula] for bruit/thrill, if buzzing sensation is pronounced or bruit is absent notify MD". In addition, although there is a general care plan for skin integrity to apply barrier cream as needed, there is no care plan for the current open buttocks wound.

Per interview on 02/14/13 at 10:00 A.M. the Unit Manager stated that Resident #29 "just scratches" and was not aware of the open sores. S/he confirmed that the fistula is no longer functioning and that the care plan is not revised to reflect the new open wound and monitoring for the port.

F 280

**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 open areas and/or any port and/or fistula have the potential to be affected by this alleged deficient practice. All residents with behavioral issues have the potential to be affected by this alleged deficient practice.

**3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:**

All residents in the center will have their skin checked for any open areas. Treatment orders will be secured as needed and care plans will be updated with current treatment. All residents receiving dialysis will be reviewed for proper access device and the care plan will be updated. All residents with sexually inappropriate behaviors will be identified. The care plans will be revised to reflect such behaviors with clear understandable approaches to the behaviors. Nursing staff will be reeducated on the procedure to assess the resident's skin and to report any open areas. The care plan interventions for resident # 4 will be noted on the LNA assignments.

*WJB*

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F 280	<p>Continued From page 8</p> <p>2. Per review of the medical record on 2/13/13, Resident #4 was re-admitted to the facility on 5/23/11 with diagnoses that include senile dementia and depressive disorder.</p> <p>Per review of the medical record from 5/2012 to 2/14/2013, Resident #4 was noted to be sexually inappropriate (making sexual comments, touching staff inappropriately, etc) and verbally abusive on several occasions. The medical record also indicated that the facility staff attempted to educate the resident on several occasions that his/her behavior was not appropriate. The record indicated that resident was "unwilling" to receive education on 6/21/12. The medical record indicates that on all occasions where Resident #4 was sexually or verbally inappropriate, staff reminded Resident #4 of the inappropriateness of the behavior and staff encouraged resident to refrain from the behavior.</p> <p>Per review of the comprehensive review dated 6/14/12, it indicates that Resident #4 has both short and long term memory loss. The review indicates a BIMS score of 9 indicating moderate short term memory loss. The review also indicates that Resident #4's cognitive impairment fluctuates.</p> <p>Per review of the the comprehensive care plan titled "Psychotropic Medications", the care plan was last updated 9/13/12. The care plan indicates that Resident #4 has "increased sexually inappropriate remarks/behaviors to other." The care plan indicates that staff is to "set limits on</p>	F 280	<p><b><u>4. How 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?</u></b></p> <p>Audits of care plans and LNA assignments will be done weekly x 90 days with audit results reported to center QI committee.</p> <p>DNS/Designee will be responsible for compliance</p> <p><b><u>5. Dates Corrective Action will be completed:</u></b> DNS/Designee will be responsible for compliance.</p> <p>March 13 2013</p> <p><i>F880 POC accepted 3/13/13 M Higgins RN / PMC</i></p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475027</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/14/2013</b>
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F 280	<p>Continued From page 9 undesired behaviors."</p> <p>Per review of the License Nursing Assistants daily assignment sheets, there is no documentation of how to address Resident #4 sexually inappropriate behaviors and there was no documentation that Resident #4 had behaviors on the LNA assignment sheet.</p> <p>Per interview on 2/14/13 with the primary aide for Resident #4, he/she indicted that Resident #4 has sexually inappropriate behaviors and that the LNA, when they occur, tells the resident "not to do that" and the LNA indicated that he/she does not tell other staff of the behaviors. The LNA indicated that he/she was aware of Resident #4's behaviors from reading the care plan. The LNA was not able to explain what "limit setting" was and how staff utilized this intervention to change Resident #4's behaviors.</p> <p>Per interview with the Staff Educator/RN on 2/14/13, he/she confirmed that Resident #4 had sexually inappropriate behaviors. The RN reviewed the care plan and indicated that the care plan indicated "limit setting". The RN was unable to define what specific "limit setting" was utilized for Resident #4. The RN reviewed the medical record and confirmed that Resident #4 had memory loss and that educating Resident #4 regarding the inappropriateness of his/her behavior was not effective.</p> <p>Per interview with the RN on 2/14/13, he /she reviewed the care plan and confirmed that the care plan was not revised after the episodes of sexually inappropriate behaviors with resident specific interventions to prevent reoccurrence.</p>	F 280		
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F 280	Continued From page 10 The RN also confirmed that the "limit setting" intervention was not effective and the RN was unable to define specifically what staff was suppose to do to set limits on Resident #4's behaviors.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide services that meet professional standards of quality by not following a physician's order for a wound dressing, breaching infection control practices, timely administration of routine and as needed pain medication and ordered treatments. This affected 4 residents in the Stage 2 sample of 24. (Resident #107, #152, #112 and #29). Findings include:  1. Per observation on 02/11/13 at 1:58 P.M. of a wound dressing change for Resident #107, the staff nurse applied the incorrect dressing material, breached infection control practice and incorrectly wrapped the leg.  The physician order dated 01/10/13 states - "change dressing qd [every day] or q3d [every three days] as drainage decrease PRN irrigate w/ safe cleans or NS [normal saline] pack w/ Aquacell, cover w/ ABD pad wrap w/ king/curlex ACE wrap from toes to knee". During the dressing change the nurse cleaned the wound	F 281	<p><b><u>Plan of Correction</u></b> <b><u>F281</u></b> <b><u>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></b></p> <p>Resident # 107, Resident #152 and resident # 29 were not affected by this alleged deficient practice. Resident # 112 indicated a pain level of "8 out of 10."</p> <p><b><u>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:</u></b> All residents who require dressing changes, treatments and/or medication for pain have the potential to be affected by this alleged deficient practice. The nurse involved with the dressing changed has been re-educated and her competency evaluated. The nurse involved with the pain medication has been re-educated on the need to address pain as ordered by the MD.</p> <p><b><u>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:</u></b> Nurses will be re-educated and competencies done for dressing changes.</p>	

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F 281	<p>Continued From page 11</p> <p>bed with a normal saline gauze from the inside of the wound bed to the outer margins and back into the wound bed. The staff nurse then wetted a material called Alginate AG and placed it into the wound bed, covered the wound with the ABD pad/kling and proceeded to wrap the leg from the knee to the toes.</p> <p>The staff nurse stated that s/he liked to wet the material as it stays in the wound bed better and wrapping from the knee to the toes "is how I do it". Per interview with the Infection Control Nurse (ICN) on 01/13/13 at 2:55 P.M. stated the staff nurse should irrigate the wound and not rub the wound especially from a more clean area to a less area and then into the wound bed, and wrapping the leg should be from the toes to the knee. In addition, the 3M representative was called regarding the material Alginate AG, which is a fibrous material that contains silver and should not be moistened when applied. The physician ordered Aquacell contains seaweed and calcium and is not the same material as Alginate AG. The ICN confirmed that the staff nurse applied the an incorrect dressing material, breached infection control practice and incorrectly wrapped the leg.</p> <p>2. During an observation of medication administration on 02/13/13 at 10:13 A.M. the nurse administered medications untimely and one of the medications was incorrect for Resident #152. A physician order on 01/31/13 states ASA [aspirin]325 mg qd [every day] and cardizem 30 mg 4 times a day. The signed order notes the times for the cardizem as 8:00 A.M., 12:00 P.M., 4:00 P.M., and 10:00 P.M.</p>	F 281	<p>Nurses will be re-educated on the center Pain Management System. Nurses will be re-educated on following the MD order for treatments. Nurses will be re-educated on what the LNA responsibilities include.</p> <p><b><u>4. How 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?</u></b> Random audits of dressing changes will be done weekly x 90 days Random audits of medication passes will be completed weekly x 90 days The medication administration records for those residents on pain medication will be audited 5xs per week for x 30 days then twice a week for 60 days. Random interviews with LNAs weekly to determine knowledge of their job responsibilities x 90 days. Audit results will be reported through center QI committee monthly.</p> <p><b><u>5. Dates Corrective Action will be completed:</u></b> DNS/Designee responsible for compliance _March 13 2013</p> <p><i>F281 POC accepted 3/13/13 MHiggins RN/PNC</i></p>	
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F 281	<p>Continued From page 12</p> <p>The staff nurse administered ASA EC [enteric coated] and the cardiac medication cardizem 30 mg. at 10:13 A.M., two hours after the scheduled time. Per interview at 10:20 A.M., the nurse stated that the ASA EC is the stock medication that is used for ASA and confirmed that s/he "got behind on the med pass". Per interview the ADNS (Assistant Director of Nursing) &amp; MDS coordinator (Minimum Data Set) on 02/13/13 at 10:33 A.M. stated that there needs to be an order for EC or regular ASA, and they are not interchangeable. They also stated that the acceptable time frame for a med pass is "an hour either way of the times". They confirmed at that time the wrong medication was administered and the cardiac medication was not administered timely.</p> <p>3. Resident #112 did not receive pain medication in a timely manner. The Resident was admitted with a diagnosis of Osteoarthros of pelvic/thigh/lower leg, lumbosacral spondylosis and closed fracture lumbar/vertebra region. Per the physician order of 02/13/13 the resident had scheduled pain medication Oxycontin 30 mg every 12 hours and as needed pain medication of either Tylenol 650 mg every 4 hours for pain level of 1-5 or Oxycodone 10 mg every 4 hours.</p> <p>Per observation and interview on 02/12/13 at 8:07 A.M. the resident stated to the nurse surveyor that s/he had hip pain and has been waiting for his/her meds since about 7:45 A.M., and expressed the pain at a level of "8 out of 10". Per interview of the LNA on 02/12/13 at 8:15 A.M. stated that s/he told nursing at change of shift (7:45 A.M.). Per review of the MAR (Medication</p>	F 281		

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F 281	<p>Continued From page 13</p> <p>Administration Record), pain medication was given at 8:30 A.M., Oxycodone 10 mg. Per interview at 8:56 A.M. the nurse stated s/he got busy with the insulin which has to be done before breakfast and would've gotten there (to administer pain medication to Resident #112) after the insulins. S/he confirmed that the resident should have been able to take the PRN (as needed) pain medication at 7:45 A.M. per the physician's orders.</p> <p>4. Per observation, record review and interview, Resident #29 did not receive treatments as ordered. Per the physician's order dated 12/26/12 states apply A&amp;D ointment to the buttocks b.i.d [twice daily] with a ABD pad. Per review of the TAR [treatment administration record], nursing staff documented 10 out of possible 26 opportunities for the treatment as being done. Per interview and observation on 02/11/13 at 3:58 P.M. Resident #29 indicated that s/he was having pain from the sore on the buttocks. During observation of care at that time, LNA staff applied barrier cream to the buttocks which had four open areas with redness as well as drainage noted on the depends. Per interview on 02/13/13 at 3:39 P.M. the Unit manager confirmed the treatment is "supposed to be done by nursing staff" and treatment was not provided as ordered.</p> <p>Also see F441 and F353 Reference: Lippincott Nursing Manual, Williams &amp; Wilkins, 8th edition</p>	F 281		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282

Continued From page 14

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:  
Based on interview and record review, the facility failed to assure that services were provided in accordance with the resident's plan of care for 4 of 24 residents in the Stage 2 sample (Residents #112, #148, #105 and #96). Findings include:

1. Per record review on 02/12/13 Resident #112's diagnoses include lumbosacral spondylosis, osteoarthroses pelvic/thigh region and a closed fracture of lumbar vertebra. Per review of the care plan dated 5/21/12 states "pain will be controlled at acceptable level as evident by [resident] verbalization, continue to monitor, assess location and severity and aggravating or alleviating factors, pre rate and post rate of meds and ensure acceptable pain level for [resident], assess pain scale 0-10, monitor the need to implement other modalities for pain control, heat/ice, rest, reposition, and analgesic rubs, consult therapy for other modalities for pain control, consult MD PRN [as needed]".

The current quarterly MDS assessment indicates that the resident "has constant pain that interferes with sleep and is on a scheduled pain med regime". Per the MAR (medication administration record) staff are to monitor pain every shift, and can administer:  
A) Tylenol 325 mg 2 tabs every 4 hours PRN pain

F 282

**Plan of Correction**  
**F282**  
**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**

Resident # 112 indicated a pain level of "8 out of 10." Pain medication is being given as per MD order.

Resident # 148 was not adversely affected this alleged deficient practice. The resident is being offered fluids and fluid intake is being monitored on each shift. The resident is being asked to attend activities and an activity calendar has been provided. Resident #148 did express a pain level of a consistent "8."

The resident does not have skin breakdown.

Resident's heels have been elevated; the resident has been encouraged to keep heels elevated.

Resident # 105 was not affected by this alleged deficient practice.

The resident has been asked to consent to a hearing evaluation. Appropriate activities for hearing impaired residents will be offered. Resident #96 now has a concave mattress.

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F 282	<p>Continued From page 15 scale 1-5; B) oxycodone 10 mg IR 1 tab every 4 hours PRN as needed - give with 650mg APAP [acetaminophen]; C) OxyContin 30 mg every 12 hours.</p> <p>Review of the MAR shows inconsistent monitoring on the shifts. Per review of the treatment record [TAR] staff are able to apply "warm compresses to right knee PRN". However, this intervention was not used for the months of January nor February 2013.</p> <p>Per interview on 02/12/13 at 8:07 A.M. Resident #112 did not want to be interviewed as s/he had stated "I am having hip pain, I've been waiting for my meds for a while, the girls know". The resident stated that s/he requested something for pain between 7:30 -7:45 a.m. but was told that nursing was in report.</p> <p>Per observation on 02/12/13 at 8:15 a.m. the resident requested pain medication again with a pain level of "8" out of 10, however waited until 8:30 A.M. until the medication was administered. Per interview the nurse at 8:36 A.M. stated "I got busy with the insulins" and verified other modalities were not tried. Per interview on 02/14/13 at 1:38 P.M. the Unit Manager confirmed care and services were not provided according to the care plan.</p> <p>2. Per record review, Resident #148 was admitted to the facility 10/12/12 with diagnoses that included; Chronic Obstructive Pulmonary Disease, Obesity, Abdominal and Hip Pain, Urinary Retention, and Irritable Bowel Syndrome.</p>	F 282	<p><b><u>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:</u></b></p> <p>All residents who experience pain, or require specific fluid intake and equipment to prevent falls have the potential to be affected by this alleged deficient practice. All residents with hearing impairment and those residents wishing to attend activities have the potential to be affected by this alleged deficient practice.</p> <p><b><u>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:</u></b></p> <p>Nurses will be re-educated on the center Pain Management System. Nurses will be re-educated on resident fluid intake and the need to monitor. Nurses will be reeducated on the center Skin Management System. Nurses will be re-educated on the center Fall Management System. LNA staff will be re-educated on the need to offer fluids in addition to those fluids served at meal time and to document when taken.</p> <p>The activity staff has been reeducated on the need to offer activities those that residents who do not regularly attend activity programs.</p>	

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F 282

Continued From page 16

Per interview with Resident #148 on 2/11/13, he/she indicated that he/she does not receive fluids in-between meals.

Per direct observation from 2/11/13 through 2/14/13, there were no fluids given to Resident #148 between meals. Per review of the comprehensive care plan titled "Nutritional Care Plan" the care plan indicates that staff is "to encourage food and fluid intake with and between meals." Per review of the nutritional assessment dated 1/17/13, Resident #148 was to consume between 1925-2310 cc's (cubic centimeters) of fluid in 24 hours.

Per review of the fluid consumption intake record, Resident #148 did not receive the recommended amount of cc's of fluid in a 24 hour period on the following dates: 1/19 (610cc's), 1/20 (720cc's), 1/21 (840cc's), 1/22 (1380cc's), 1/23 (1500cc's), 1/24 (840cc's), 1/25 (600cc's), 1/26 (840cc's), 1/27(1300cc's), 1/28 (1780cc's), 1/29 (1080cc's), 1/30 (840cc's), 1/31 (360cc's), 2/1 (720cc's) 2/2 (1360cc's), 2/3 (1460cc's), 2/4 (780 cc's), 2/5 (1200cc's), 2/6 (1500cc's), 2/7 (900cc's), 2/8 (960cc's), 2/9 (780cc's), 2/10 (1680cc's) 2/11 (300 cc's), 2/12 (1560cc's) and 2/13 (1400cc's).

Per review of the medication administration record Resident #148 takes a diuretic daily. Per review with a staff Registered Nurse on 2/14/13, he/she reviewed the medical record and the fluid consumption intake record and confirmed that there was no evidence that Resident #148 had been encouraged to consume fluids between meals and the RN confirmed that the daily fluid intake did not match the recommendations from dietary and the RN confirmed that the

F 282

Any resident with a hearing impairment will be identified and activities reviewed for appropriateness

**4. How 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?**

Audits of pain medication administration and MAR documentation will be completed 5 x weekly x 30 days and then 2 x weekly x60 days.  
I&O records will be audited daily x 90 days.  
Activity calendars and activity attendance records will be audited weekly x 90 days

Random audits of resident positioning will be done daily x 30days then twice a week x 60 days

**5. Dates Corrective Action will be completed:**

DNS/Designee responsible for compliance  
March 13 2013

*F282 POC accepted 3/13/13  
MTHqms RN/PMC*

*WLB*

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F 282	<p>Continued From page 17</p> <p>comprehensive care plan was not followed to "encourage fluid intake with and between meals."</p> <p>3. Per interview on 2/11/13, Resident #148 indicated that he/she does not participate in the facility activities program and was not aware of what activities the facility has. Per direct observation from 2/11/13 through 2/14/13, Resident #148 was observed in his/her room in bed all day except for meals.</p> <p>Per review of the comprehensive care plan, titled "Activities", Resident #148 needs staff encouragement to attend out of room activities daily. Per interview with the facility Activities Director, he/she reviewed the activity logs for Resident #148 and confirmed that he/she had not attended facility activities outside of his/her room 9 out of 14 opportunities. The Activities Director reviewed the care plan and confirmed that the care plan indicated to encourage Resident #148 to attend out of room activities daily. The Activities Director also confirmed that there was no documentation that indicated that Resident #148 was offered activities and refused. The Activities Director confirmed that Resident #148 and the rest of the residents on the 3rd floor had not had activities on the unit on 2/13 and 2/14 because the Activities department did not have enough staff to conduct the planned activities on the 3rd floor.</p> <p>4. Per interview on 2/11, 2/12, 2/13 and 2/14, Resident #148 indicated that he/she had continual pain in his/her hip, abdomen and back. Resident #148 confirmed in interview on 2/11, 2/12, 2/13 and 2/14 that the pain on a scale of 1-10 (10 being most painful) that his/her pain was</p>	F 282		
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NAME OF PROVIDER OR SUPPLIER  <b>BENNINGTON HEALTH &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2 BLACKBERRY LANE BENNINGTON, VT 05201</b>		
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F 282	<p>Continued From page 18</p> <p>a consistent 8. Per interview, Resident #148 indicated that the pain medication he/she receives does not relieve his/her pain. Per interview, Resident #148 indicated that his/her pain interferes with his/her sleeping, eating and participation in activities.</p> <p>Per review of the care plan titled "Pain" and last reviewed on 1/3/13, the care plan indicates that Resident #148 "pain level will be brought down to comfortable levels". The care plan indicates his/her pain is located in the abdomen and back and that his/her current pain regimen is Vicodin 5/500mg by mouth every 6 hours as needed for pain. The care plan also indicates that staff is to rate residents pain pre and post medication, implement other modalities for pain control ;( heat, analgesic rub, repositioning, rest and massage.), and to notify the physician if pain is not controlled.</p> <p>Per review of the medication administration record, Resident #148 received Vicodin for pain 12 times from 2/1/13 thru 2/13/13. Per review of the medication administration record and the medical record there was no evidence that pre and post pain levels were completed, and no evidence that other modalities had been tried to relieve the pain of Resident #148. Per review of the medical record there was no evidence that the physician had been informed that Resident #148's pain was uncontrolled.</p> <p>Per review of the comprehensive assessment (MDS) dated 10/19/12, the assessment indicates Resident #148 has frequent pain, that has limited his/her day to day activities in the 5 days of the assessment period, and the pain intensity is an</p>	F 282			

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F 282	<p>Continued From page 19</p> <p>"8". Per review of the facility policy/procedure titled "Pain-Clinical Protocol", it indicates that, "staff will provide elements of a comforting environment and appropriate physical and complementary interventions," and "discuss significant changes in levels of comfort with the Attending physician".</p> <p>Per review with the facility Staff Educator/RN he/she confirmed after review of the medication administration record and the medical record for Resident #148, that Resident #148 was having unrelieved pain and that the physician had not been notified. The RN also confirmed that there is no documentation of the pre and post pain scores where and no evidence that alternative pain relieving methods were utilized to relive Resident #148's pain. The RN confirmed that the care plan titled "Pain" had not been implemented to meet the pain needs of Resident #148.</p> <p>5. Per observation on 2/14/13 while staff was providing AM (morning) care, Resident #148 was noted to be in bed with his/her heels touching the mattress. Per review of the medical record and comprehensive assessment, Resident #148 is at high risk for skin breakdown related to impaired mobility, obesity and history of cellulitis. Resident #148 does not ambulate and spends all his/her time in bed or in chair. Per review of the comprehensive care plan titled "Pressure Ulcers" last reviewed and revised on 12/17/12, it indicates that Resident #148 is "to have [his/her] heels on a pillow in bed".</p> <p>Per interview with the Licensed Nursing Assistant (LNA) on 2/14/13, he/she indicated that the care plan indicates what care is to be provided to the</p>	F 282		
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F 282	<p>Continued From page 20</p> <p>resident and that the care plan for Resident #148 indicates that his/her heels are to be elevated on pillows while resident is in bed and that his/her heels were not elevated on pillows as indicated by the care plan.</p> <p>6. Per record review, Resident #105 was admitted to the facility on 9/14/11, with diagnoses that include dementia and depressive disorder. Per interview with Resident #105 on 2/11/13, he/she indicated that he/she does not participate in the facility activity programs because "[he/she] can not hear so why bother." Resident #105 indicates he/she just stays in his/her room except for some meals.</p> <p>Per direct observation from 2/11/13 through 2/14/13, Resident #105 was observed in his/her room in bed all day. Per review of the comprehensive care plan, there was no documentation regarding Resident #105's specific hearing needs and interventions that would assist Resident #105 with participating in out of room activities.</p> <p>Per interview with the facility Activities Director, he/she reviewed the activity logs for Resident #105 and confirmed that Resident #105 had not attended facility activities outside of his/her room. The Activities Director confirmed that he/she was unaware that Resident #105 was failing to participate in out of room activities related to Resident #105's inability to hear. The Activities Director reviewed the care plan and confirmed that the care plan did not indicate any resident specific interventions to assist Resident #105 with activities that require the ability to hear. The Activities Director also confirmed that there was</p>	F 282			

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F 282 Continued From page 21  
no documentation that indicated that Resident #105 was offered activities and refused. The Activities Director confirmed that Resident #105 had not received one to one visits per the care plan on 2/2, 2/3 and 2/11 because the Activities Department did not have enough staff to accommodate in room visits with residents.

F 282

7. Per observation, record review and staff interview, the facility failed to provide services according to the resident's plan of care. Per 2/13/2013 record review at 4:30 PM, Resident #96 presents with a diagnosis of Lewey Body type dementia, History of falls, Neuropathy, Diabetes and is on cardiac medications. Her/His Care Area Assessment (CAA) dated 10/1/2012 further indicated that the resident is at risk for falls secondary to unsteady balance/gait and psychotropic medications. Recent falls occurred on 1/20/2013 during attempt to independently ambulate and again on 1/26/2013 when he/she rolled out of bed. The care plan indicates that the resident is to have bed and rise alarms as well as a concave mattress on the bed. Per direct

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F 282	Continued From page 22 observation on 2/13/2013 at 9:30 AM Resident #96 did not have a concave mattress on the bed. This was verified by the LNA on duty at 9:30 AM on 2/13/13.	F 282		
F 309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure that services were provided to meet the highest practicable well-being for 4 of 24 residents in the Stage 2 sample regarding pain control and skin integrity. (Resident #112, #29 and #148).</p> <p>1). Per record review on 02/12/13 Resident #112's diagnoses include lumbosacral spondylosis, osteoarthritis pelvic/thigh region and a closed fracture of lumbar vertebra. Per review of the care plan dated 5/21/12 states "pain will be controlled at acceptable level as evident by [resident] verbalization, continue to monitor, assess location and severity and aggravating or alleviating factors, pre rate and post rate of meds and ensure acceptable pain level for [resident], assess pain scale 0-10, monitor the need to implement other modalities for pain control, heat/ice, rest, reposition, and analgesic rubs,</p>	F 309	<p><b><u>Plan of Correction</u></b> <b><u>F309</u></b></p> <p><b><u>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></b> Resident #112's pain was described as an 8" out of 10. Pain medication was administered. Resident# 29 was not affected by this alleged deficient practice. The nurse responsible for the pain medication administration has been re-educated.</p> <p><b><u>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:</u></b> All residents who experience pain or have MD orders for specific treatments have the potential to be affected by this alleged deficient practice. MD orders for those residents on pain medication will be reviewed.</p> <p><b><u>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:</u></b> MARs (medication administration records) will be reviewed for timely and appropriate</p>	

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F 309 Continued From page 23  
consult therapy for other modalities for pain control, consult MD PRN [as needed]".

The current quarterly MDS assessment indicates that the resident "has constant pain that interferes with sleep and is on a scheduled pain med regime". Per the MAR (medication administration record) staff are to monitor pain every shift, and can administer:  
A) Tylenol 325 mg 2 tabs every 4 hours PRN pain scale 1-5;  
B) oxycodone 10 mg IR 1 tab every 4 hours PRN as needed - give with 650mg APAP [acetaminophen];  
C) OxyContin 30 mg every 12 hours.

Review of the MAR shows inconsistent monitoring on the shifts. Per review of the treatment record [TAR] staff are able to apply "warm compresses to right knee PRN". However, this intervention was not used for the months of January nor February 2013.

Per interview on 02/12/13 at 8:07 A.M. Resident #112 did not want to be interviewed as s/he had stated "I am having hip pain, I've been waiting for my meds for a while, the girls know". The resident stated that s/he requested something for pain between 7:30 -7:45 a.m. but was told that nursing was in report.

Per observation on 02/12/13 at 8:15 a.m. the resident requested pain medication again with a pain level of "8" out of 10, however waited until 8:30 A.M. until the medication was administered. Per interview the nurse at 8:36 A.M. stated "I got busy with the insulins" and verified other modalities were not tried. Per interview on

F 309 administration.  
Residents who are identified as having pain medication orders will be interviewed for appropriate and timely pain administration. TARS will be audited for completion. Nurses will be re-educated as to those treatments that require the nurse to perform. LNAs will be re-educated as to their job responsibility for any treatment. Random interviews with LNAs will be conducted to ensure they are performing only those procedures with in scope of practice.

**4. How 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?**

MAR audits for pain 5 x a week for 30 days then twice weekly for 60 days.  
TAR audits 5 days a week x 4 weeks then twice a week x 60 days.  
Random interviews of LNA's will be conducted weekly x 90 days.

**5. Dates Corrective Action will be completed:** ADNS, Nurse Mgrs, SDC or designee  
March 13 2013

F309 POC accepted 3/13/13  
Mtiqmsrn / PMC

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F 309	<p>Continued From page 24</p> <p>02/14/13 at 1:38 P.M. the Unit Manager confirmed care and services were not provided to meet the resident's highest practicable well-being.</p> <p>2. Per observation, record review and interview Resident #29 did not receive treatments to meet the highest practicable physical well-being. Per the physician's order dated 12/26/12 states apply A&amp;D ointment to the buttocks b.i.d [twice daily] with a ABD pad. Per review of the TAR [treatment administration record] nursing staff documented 10 out of possible 26 opportunities for the treatment as being done. Per interview and observation on 02/11/13 at 3:58 P.M. Resident #29 indicated that s/he was having pain from the sore on the buttocks. During observation of care at that time, LNA staff applied barrier cream to the buttocks which had four open areas with redness as well as drainage noted on the depends. Per staff interview on 02/12/13 at 12:04 P.M. the staff nurse stated that the resident did not have any open areas and LNAs apply barrier cream. Per interview on 02/13/13 at 3:39 P.M. the Unit manager confirmed the treatment is "supposed to be done by nursing staff" and treatment was not provided meet the resident's highest practicable well-being.</p> <p>3. Per interview on 2/11, 2/12, 2/13 and 2/14, Resident #148 indicated that he/she had continual pain in his/her hip, abdomen and back.</p>	F 309		
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F 309 Continued From page 25

Resident #148 confirmed in interview on 2/11, 2/12, 2/13 and 2/14 that the pain on a scale of 1-10 (10 being most painful) that his/her pain was a consistent 8. Per interview Resident #148 indicated that the pain medication he/she receives does not relieve his/her pain. Per interview, Resident #148 indicated that his/her pain interferes with his/her sleeping, eating and participation in activities.

Per review of the care plan titled "Pain" and last reviewed on 1/3/13, the care plan indicates that Resident #148 "pain level will be brought down to comfortable levels". The care plan indicates his/her pain is located in the abdomen and back and that his/her current pain regimen is Vicodin 5/500mg by mouth every 6 hours as needed for pain. The care plan also indicates that staff is to rate residents pain pre and post medication, implement other modalities for pain control ;( heat, analgesic rub, repositioning, rest and massage. ), and to notify the physician if pain is not controlled.

Per review of the medication administration record; Resident #148 received Vicodin for pain 12 times from 2/1/13 thru 2/13/13. Per review of the medication administration record and the medical record there was no evidence that pre and post pain levels were completed, and no evidence that other modalities had been tried to relieve the pain of Resident #148. Per review of the medical record there was no evidence that the physician had been informed that Resident #148's pain was uncontrolled.

Per review of the comprehensive assessment (MDS) dated 10/19/12, the assessment indicates

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F 309 Continued From page 26  
Resident #148 has frequent pain, that has limited his/her day to day activities in the 5 days of the assessment period, and the pain intensity is an "8". Per review of the facility policy/procedure titled "Pain-Clinical Protocol", it indicates that, "staff will provide elements of a comforting environment and appropriate physical and complementary interventions," and "discuss significant changes in levels of comfort with the Attending physician".

F 309

Per review with the facility Staff Educator/RN he/she confirmed after review of the medication administration record and the medical record for Resident #148, that Resident #148 was having unrelieved pain and that the physician had not been notified. The RN also confirmed that there is no documentation of the pre and post pain scores where and no evidence that alternative pain relieving methods were utilized to relieve Resident #148's pain. The RN confirmed that the care plan titled "Pain" had not been implemented to meet the pain needs of Resident #148.

F 315 483.25(d) NO CATHETER, PREVENT UTI, SS=D RESTORE BLADDER

F 315

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

**Plan of Correction**  
**F315**  
**I. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**  
Resident # 52 continued to experience occasional incontinence. An individualized training program has been developed. The care plan has been updated to indicate occasional incontinence and the initiation of the bladder training program. The physician has been notified and resident has been assessed for any medical intervention.

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F 315 Continued From page 27  
This REQUIREMENT is not met as evidenced by:  
Based upon staff interview and record review, the facility failed to ensure one resident (Resident #52) of three residents in the sample group received appropriate treatment and services for bladder incontinence. Findings include:

Per record review, Resident #52's Admission Nursing Evaluation on 8/11/11 records the resident always voids correctly without incontinence. Per review, Resident #52's MDS [Minimum Data Set] assessments from 10/23/11 to 7/10/12 record no incidents of incontinence, and the facility's Comprehensive Review of Activities of Daily Living [ADLs] for Resident #52 on 7/11/12 reports "[The resident] is independent with toileting, and has been continent of bowel and bladder". Per record review Nursing Notes, dated 7/14/12 document Resident #52 was "incontinent of urine today".

Resident #52's Plan of Care for ADLs, dated 10/14/12, documents the resident was incontinent of bladder one time, and " if incontinence persists will reassess and follow up as needed. Continue Plan of Care". On 12/13/12, Resident #52's MDS for Urinary Incontinence reflects s/he is "occasionally incontinent". A Genitourinary Assessment completed the next day documents the resident is a "Good Candidate" for individualized training and for the facility to complete a bowel and bladder retraining evaluation.

Per record review of Nursing Notes dated 2/6/13 "Checked on [resident] a few minutes later and [h/she] was standing in front of the sink and had

F 315

**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 experience sudden incontinence or occasional incontinence have the potential to be affected by this alleged deficient practice.

**3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:**  
All residents will be audited for sudden and/or occasional incontinence. Appropriate residents will be evaluated as per policy and procedure and an individualized training program will be developed if appropriate.

**4. How 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?**  
Training programs will be monitored daily x 30 days.  
Nursing management in conjunction with the resident and physician will evaluate the effectiveness of the bladder training program.

**5. Dates Corrective Action will be completed**  
DNS/Designee responsible for compliance  
March 13 2013

*WJB*

F315 POL accepted 3/13/13  
MHiqms RJA/MLC

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/14/2013
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NAME OF PROVIDER OR SUPPLIER  BENNINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2 BLACKBERRY LANE BENNINGTON, VT 05201
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F 315 Continued From page 28  
urinated on floor". Per staff interview with the Charge Nurse on Resident #52's unit on 2/14/13 at 1:20 P.M. the Nurse observed the resident on 1/29/13 with obvious soaking wet pants. The Charge nurse stated this was a recent and noticeable change for the resident, and the Charge Nurse confirmed that Resident #52's MDS demonstrated a decline in h/her condition and function. The Charge Nurse stated per the facility's Genitourinary Assessment on 12/14/12 a bladder retraining evaluation should have been completed along with a Bowel and Bladder Voiding Assessment tool, but was not.

F 315

Additionally, the Charge Nurse stated it was h/her expectation that a care plan for incontinence would be put in place for the resident, and there was none on the resident's written chart, and per interview on 2/14/13 at 1:27 P.M. with the facility's Infection Control Nurse there is no active care plan on the facility's computerized care system regarding Resident #52's incontinence.

F 329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

F 329

**F329**

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not

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

Resident #125 had no negative outcome from this alleged deficient practice. The resident's physician reviewed the use of the antipsychotic. The physician was agreeable to reducing one dose a week at this time.

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F 329	Continued From page 29 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 1 of 10 applicable residents in the stage 2 sample were free from unnecessary drugs (Resident #125). Findings include:  1. Per record review on 02/13/13, Resident #125 was administered an anti-psychotic without attempting non-pharmacological interventions and without adequate monitoring of behaviors. Resident #125's diagnoses include: dementia with behaviors, depression, diabetes and cardiac history. Per review of the plan of care and CAA review dated 12/18/12, upon an original admission into the facility in April 2012 the resident was on Risperdal (an anti-psychotic medication) and Trazadone (an anti-depressant) however, both were "successfully discontinued" in Oct 2012 and "behaviors are well-controlled". The care plan for mood/behaviors/psychotropic medication, directs staff to "continue to monitor mood and behaviors" as well as "if [resident] is restless the staff will attempt to determine	F 329	<b><u>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:</u></b>  Residents on antipsychotics are at risk  <b><u>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:</u></b> Nurses will be educated about the use of antipsychotics, interventions to be tried and documented prior to starting or restarting antipsychotics. New orders will be reviewed at morning meeting. Center Pharmacy Consultant will continue to monitor psychotropic drug use and reduction and make recommendations to the MD.  <b><u>4. How 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?</u></b> Residents on antipsychotics, reduction of psychotropic medication or discontinuation of psychotropic medication will be reviewed for appropriate documentation on a weekly basis x 60 days, then monthly x 3s with audit results reported through QAA monthly.  <b><u>5. Dates Corrective Action will be completed:</u></b> DNS/Designee responsible for compliance March 13 2013	

*WJB*  
F329 POC accepted 3/13/13  
M Higgins RN / PMLC

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F 329	<p>Continued From page 30</p> <p>cause...and will rule out medical cause if increased behaviors are present". The Resident who was re-admitted to the facility on 12/12/12 after a total knee replacement, was not identified as having behaviors while in the hospital nor was on Risperdal upon the re-admission to the nursing home.</p> <p>Per a nursing note on 02/15/13 at 5:45 P.M. states "approached pt [patient] and asked how can [s/he] be helped to which pt loudly and angrily replied that [s/he] needed Tylenol and something to be done about [her/his] tongue. Pt has a sharp bothersome tooth upper R side and states [s/he] has a care plan meeting coming up but nobody can give [her/him] any answers. This nurse assessed pt pain and administered one vicodin PO [by mouth] with positive effect pt sleeping and appears comfortable at 2100 [9:00 p.m.]'. Assured pt that [her/his] tooth will be addressed at care plan meeting; pt very upset noted to be grinding teeth with a facial twitch and had a threatening energy about [her/him], however up until this point this evening pt had denied pain and was of benign spirits. Message left for floor manager regarding pt concern for care plan and dental attention."</p> <p>Per the care plan meeting social service note on 12/19/12 states "[resident] is very frustrated and angry grimacing while [s/he] talks will call [doctor] for clearance for extractions [spouse] does feel [s/he] is more agitated [spouse] is taking [her/him] home for the holidays this is typically hard time for[her/ him] per history". Per the nursing note on 12/20/12 states "Pt refused 1600 [4:00 p.m.] chem stick stating [s/he] wasn't going to eat the food and used a string of curse words</p>	F 329		
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F 329 Continued From page 31  
to describe lunch, However pt did then apologize for [her/his] language but continued to speak angrily. At 1735 [5:35 p.m.] pt was found at nurses cart requesting gum for [her/his] teeth and again cursing and angry. This nurse is unable to leave facility to purchase gum this evening but assured pt that if it couldn't be provided this evening we would do our best to get [her/him] some gum the following day. Pt has a very threatening demeanor making staff and residents uneasy..."

Per a FAX from the LPN to the physician on 12/21/12 states "requesting Risperdone 0.75 mg b.i.d. [twice a day]...for increase belligerent behaviors verbally abusive ...was d/c in Oct".

Per review of the medical chart, treatment records and MAR, non-pharmacological interventions were not implemented prior to administration of the anti-psychotic Risperdal and no evidence of documented clinical rationale through monitoring of quantitatively specific objective behaviors which are not caused by preventable reasons or causing a present danger to self and others.

Per interview at 5:03 P.M. on 2/13/13 the Unit Manager and MDS coordinator said the process is that the facility documents and monitors the behavior by the daily report by nursing and review with the doctor and pharmacist as a team. They also stated, "we are trying to have the nurses not just fax to the doctor and to follow the process but this did not happen". They confirmed that staff were suppose to monitor and document the behaviors and the LPN didn't rule out other issues or used other intervention prior to

F 329

*WSB*

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<p>F 329</p> <p>F 353 SS=F</p>	<p>Continued From page 32 administering an anti-psychotic.</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to assure sufficient staff to provide nursing and related services to maintain the highest practicable well-being of each resident according to residents' assessments and individual plans of care for 3 of 24 residents in the Stage 2 sample. (Resident #37, #112, #152) Findings include:</p>	<p>F 329</p> <p>F 353</p>	<p><b><u>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></b></p> <p>Resident #37 was not affected by this alleged deficient practice. The resident was fed the meal.</p> <p>Resident #112 reported a pain level of "8" out of 10. The resident did receive the pain medication.</p> <p>Resident # 152 was not affected by this alleged deficient practice.</p> <p>Any resident requiring assistance with meals and those receiving medications have the potential to be affected by this alleged deficient practice.</p> <p><b><u>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:</u></b></p> <p>Residents receiving or requesting pain medication are at risk for this deficient practice.</p> <p>Residents that eat in their rooms are at risk for this deficient practice.</p>	
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F 353 Continued From page 33

1. Resident #37 did not receive his meal tray for greater than 30 minutes after the roommate's tray came. Resident #37 who is assessed as needing total assistance with feeding watched the roommate eat during this time. The roommate received the meal tray at 12:10 PM and Resident #37 received the meal tray and was fed at 12:45 PM. Staff acknowledged that Resident #37's roommate (who also needs assistance) had a private person to help and that is why the roommate was eating before Resident #37. Per staff interview at that time stated that the procedure is to serve the residents in the dining room first, then residents who are able to eat on their own in their rooms and then the residents that need assistance with eating are served last. The Unit Manager at on 02/11/13 at 1:00 P.M. confirmed the above finding.

2. Resident #112 did not receive pain medication in a timely manner. The admission assessment of 05/12/12 notes the resident for "having constant pain that interferes with sleep and is on a scheduled pain med regime". The pain level was 7 out of 10 during the assessment. Per observation and interview on 02/12/13 at 8:07 A.M. the resident stated to the nurse surveyor that s/he had hip pain and had been waiting for his/her meds since about 7:45 A.M., and expressed the pain at a level of "8 out of 10".

Per interview of the LNA on 02/12/13 at 8:15 A.M. stated that s/he told the nurse at change of shift [7:45 A.M.] when the nurse was getting report. Per the physician order of 02/13/13 the resident had scheduled pain medication Oxycontin 30 mg every 12 hours and PRN [as needed] pain medication of either Tylenol 650 mg every 4

F 353

**3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur;**

The nurse(s) involved in the medication pass have been re-educated regarding timely administration.

LNAs have been reeducated on the need to serve and assist both residents in the same room at the same time.

Hospice staff has been requested to notify the nurse if they will be feeding their client on any day.

An assessment of the nursing needs of the residents on the 3<sup>rd</sup> floor on the night shift will be completed.

The resident identified as requiring 1:1 attention if (he/she) awakes now sleeps through the night.

No other residents awoken and require 1:1 attention at this time.

Medication administration on the night shift will be reviewed and changes made if appropriate in consultation with the attending physicians.

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F 353 Continued From page 34  
hours for pain level of 1-5 or Oxycodone 10 mg every 4 hours as needed for break through pain. Per review of the MAR, pain medication was given at 8:30 A.M. as Oxycodone 10 mg. Per interview at 8:56 A.M. the nurse confirmed and stated "I got busy with the insulin which has to be done before breakfast and got there after the insulins". S/he confirmed that resident waited 45 minutes before receiving pain medication.

3. During an observation of medication administration on 02/13/13 at 10:13 A.M. the nurse administered a cardiac medication untimely for Resident #152. A physician order on 01/31/13 states cardizem 30 mg 4 times a day. The signed order notes the times as 8:00 A.M., 12:00 P.M., 4:00 P.M., and 10:00 P.M. The staff nurse administered the cardiac medication cardizem 30 mg. at 10:13 A.M. two hours after the scheduled time. Per interview at 10:20 A.M. the nurse stated and confirmed that s/he "got behind on the med pass, there was a lot going on". Per interview the ADNS [Assistant Director of Nursing] & MDS coordinator [minimum data set] on 02/13/13 at 10:33 A.M. stated that the med pass is "an hour either way of the times". They confirmed the cardiac medication was not administered timely.

Per interview at 1:38 P.M. on 02/14/13 the Unit Manager stated that "the south side has heavy care with trachs, IV, PICC lines, colostomy and blood work...they are all sick and unstable and North, that's a nightmare". S/he expressed "all that contributes to the late meds" and confirmed that "it was too much for one nurse".

4. Per record review and staff interview the

F 353

**4. How 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?**  
Meal tray distribution will be audited to ensure timely assistance for residents 3 x a week x 90 days.  
Medication administration will be audited 3x a week x 90 days  
Rounds will be made on the night shift for adherence to schedules to meet the needs of the residents on night shift.

**5. Dates Corrective Action will be completed:** DNS/Designee responsible for compliance  
March 13 2013

*F353 POC accepted 3/13/13  
MTHqms RN/PWK*

*WJB*

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F 353	<p>Continued From page 35</p> <p>staffing on the 3rd floor unit (B) is as follows: According to record review on 02/14/2013 the usual staffing on the 3rd floor during the night shift is 1 nurse (LPN or RN) and 2 LNAs (Licensed Nursing Assistants) for a unit with a present census of 42 and a capacity of 49. In an interview on 02/11/2013 the Unit Manager on 3rd floor stated that the floor has a "about 50/50 split of long-term care and wandering residents."</p> <p>In an interview on 02/14/2013 at 8:45 AM a staff member wishing to remain anonymous stated that, in the event that the one resident on the 3rd floor requiring 1:1 staffing awoke, the staff working on the unit would rotate providing the special coverage until he was asleep again. It was stated that care during rounds usually requires 2 LNAs and that the LNAs usually round together. S/he further stated, when questioned, that given the resident needs and staffing, rounds could not be made every two hours. (By calculation 2 LNAs rounding and providing care on 42 residents, allotting 5 minutes per resident equals 3 hours and 30 minutes per round).</p> <p>In a review of resident needs on the 3rd floor on 02/14/2013 at 9:40 AM with a facility nurse, the following information regarding 3rd floor resident demographics was relayed: Hoyer Lifts (2 person)-8 2 person transfers-17 1 assist transfers-14 2 person assist for bed mobility- all residents requiring being moved up to the head of the bed 21 residents for other bed mobility 1 person assist for bed mobility-16 2 person assist with care-16 1 person assist with care-25</p>	F 353		

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F 353	<p>Continued From page 36</p> <p>The duties of the nurse on the unit at night include: Monitoring a continuous tube feeding running over 6 hours via feeding pump and providing flushes as ordered; Monitoring residents with PICC line, wound vac, Every 15 min neuro checks, AM fingersticks; Administering routine and PRN medications as ordered; Making staffing calls when there is a call-in for the day shift; Charting and paperwork as required; Assisting LNAs as needed; Monitoring any residents who have had a change in condition or a fall; Making nursing rounds on all residents.</p> <p>In an interview on 02/14/2013 at 10:40 AM the Administrator and the Staff Development nurse stated that they were aware of, and had made changes to correct a staffing issue on the evening (3P-11P) shift but they were not aware of issues on the 3rd floor at night (11P-7A). They stated that they are not aware that the resident requiring 1:1 staffing has awakened during the night shift.</p> <p>Per interview of a family member, wishing to remain anonymous, on 2/11/2013 at 4:04 PM staffing concerns were presented. "Staff coverage has always been problematic, but now it has gotten to be intolerable." S/he continued to relay that there is a resident that needs one to one supervision because s/he is constantly walking into other resident rooms and s/he hits LNAs. "They do not replace the LNA that covers one to one coverage." The family member further stated that the resident's "care is neglected</p>	F 353		
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F 353 Continued From page 37  
because there is not enough staff." S/he also said that "Last Friday there were only two LNAs on duty and one had to be one on one and that left only one." The spouse's concern is that there is not enough staff to care for her/his spouse and others.

F 353

**Plan of Correction**  
**F356**  
**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**

F 356 483.30(e) POSTED NURSE STAFFING INFORMATION  
SS=C

The facility must post the following information on a daily basis:

- o Facility name.
- o The current date.
- o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
  - Registered nurses.
  - Licensed practical nurses or licensed vocational nurses (as defined under State law).
  - Certified nurse aides.
- o Resident census.

F 356

No resident was harmed by the alleged deficient practice

**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:**  
No resident has the potential to be affected.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:

- o Clear and readable format.
- o In a prominent place readily accessible to residents and visitors.

**3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:**  
Scheduler will receive education on adding census to the daily assignment sheet.  
Census will be added to the daily census sheet.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

**4. How 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?**

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

Daily audits of census sheet x 1 week, weekly x 4 and then monthly x4.  
**5. Dates Corrective Action will be completed:**  
DNS/Designee responsible for compliance  
March 13 2013

*WJB*

F356 PDC accepted 3/13/13  
MHA/qms RW/pnc

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/14/2013
NAME OF PROVIDER OR SUPPLIER  BENNINGTON HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 2 BLACKBERRY LANE 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 356	Continued From page 38  This REQUIREMENT is not met as evidenced by: Based upon observation and record review the facility failed to post the resident census on a daily basis as required by regulation. Findings include:  Per observation on 2/13/13 at 8:30 A.M. the facility's required daily posting of staffing was absent of the resident census number. Per record review, daily posting of the staffing for the length of the survey contained staffing hours but no resident census number, as required by regulation.	F 356		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure that pharmacy review recommendations were acted upon in a timely fashion for 1 of 24 residents in the Stage 2 sample (Resident #112). Findings include:	F 428	<u>Plan of Correction</u> <u>F428</u>  <u>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> Resident #112 had no negative outcomes from the alleged deficient practice. Remeron has been reduced. <u>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:</u> Those residents with pharmacy recommendations have the potential to be affected by this alleged deficient practice..	

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F 428	Continued From page 39  1. Per record review on 02/13/13, Resident #112 has a history of depression and migraines. A pharmacy review conducted on 10/18/12 states to the doctor "Serotonin from the antidepressant impacts as contributing to migraines?". The Resident continues to receive the anti-depressants Fluoxetine [Prozac] 20 mg at bedtime and Mirtazapine [Remeron] 30 mg at bedtime. The chart contains faxes to the physician dated 11/21/12, 11/27/12 and 12/06/12, in which there has been no response. Per interview on 02/14/13 at 1:38 P.M., the Unit Manager confirmed the the pharmacy's recommendation was not acted upon in a timely manner.	F 428	<b><u>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:</u></b> Pharmacy recommendations will be reviewed twice weekly to ensure timely action by the MD. The MD will be contacted via telephone should no response be received within in (3) business days from the faxed recommendation. Consultant pharmacist will provide a compilation report monthly of all recommendations to ensure follow-up is accomplished in a timely manner.  <b><u>4. How 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?</u></b> Recommendations will be audited weekly x4 and monthly x4. Results of audits reported to QAA monthly  DNS/or designee will be responsible for compliance.  <b><u>5. Dates Corrective Action will be completed:</u></b>  March 13, 2013 F428 POC accepted 3/13/13 M Higgins RWJ PML	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	<b><u>Plan of Correction</u></b> <b><u>F431</u></b> <b><u>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></b> All biologicals that were outdated or not in use were removed and destroyed.  No residents were affected by this alleged deficient practice.	

*WJA*

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NAME OF PROVIDER OR SUPPLIER  <b>BENNINGTON HEALTH &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2 BLACKBERRY LANE BENNINGTON, VT 05201</b>
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F 431 Continued From page 40 controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:  
Based on observation during medication storage review, the facility failed to assure that medications were disposed of according to the recommended time frame on 2 of 2 units of the facility. Findings include:

Per observation on 02/12/13 at 9:35 AM, the medication rooms located on 2nd and 3rd floors contained out-dated stock medications. The 2nd floor had containers of multi-vitamins with iron and calcium, which expired April 2012 and September 2012 respectively, while the 3rd floor had outdated stock containers of calcium which expired June 2012.

The 3rd floor the medication refrigerator contained liquid Lorazepam ( a controlled drug) for two residents who had passed away. The residents died on 01/22/13 (20 days ago) and 02/09/13 (4 days). In addition, the medication refrigerator temperatures were not consistently

F 431

**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 have the potential to be affected by this alleged deficient practice.

**3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:**  
Central supply clerk was educated on the rotation of stock medications.  
Nurses were reeducated on monitoring and documenting refrigerator temps as per policy and procedure.

**4. How 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?**  
Daily audits x 1 week ,weekly x 4 and monthly x4 for refrigerator temps\_  
Weekly audits x 4 and monthly audits x 4 for outdated biologicals.  
DNS/Designee will be responsible for compliance

**5. Dates Corrective Action will be completed:**  
March 13 2013

*F43i POC accepted 3/13/13  
Mitigations per JAME*

*WSP*

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F 431	Continued From page 41 monitored as evident by the Temperature log sheet from September 2012 through February 11, 2013. Per interview on 02/12/13 at 10:48 A.M. the Staff nurse stated "we waste them every couple of weeks because we need 2 RN's." Per review of the Policy for disposal of outdated, unused and controlled substances states "any medication for which there is no active order shall be destroyed at the nursing facility as soon as possible. 1. As soon as a medication becomes inactive, the unit charge nurse or designee should remove all supplies of the drug from stock, count the remaining doses, fill out the drug disposal log and destroy them". Per interview on 02/13/13 at 11:30 A.M. the DNS confirmed that the expectation was that the pharmacy remove outdated stock and that nursing should've disposed of the controlled substances shortly after a resident is deceased, which did not happen.	F 431	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	<u>Plan of Correction</u> <u>F441</u> <b><u>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></b> Resident #4 and resident #107 had no negative outcome from this alleged deficient practice. The bedspread was removed and replaced with a clean bedspread on resident #4 and the soiled lined was removed from the floor in room 10. The nurse was counseled on the correct procedure for a dressing on a wound

(X5) COMPLETION DATE

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F 441	Continued From page 42  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The findings include:  1. On 2/14/13 at approximately 10:30 AM, per direct observation, a Licensed Nursing Assistant (LNA) provided AM (morning) care to Resident #148. After completing peri care for Resident #148, the LNA placed the soiled wet wash cloth on the blue bed spread at the foot of Resident	F 441	<b><u>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:</u></b> <b><u>All residents have the potential to be affected by this alleged deficient practice.</u></b>  <b><u>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur;</u></b>  Staff were educated on infection control with regards to dirty linen and dressing changes on wounds <b><u>4. How 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?</u></b>  audits of linen changing and dressing changes will be done weekly x 4, monthly x 4 with results reported through QAA DNS/Designee will be responsible for compliance <b><u>5. Dates Corrective Action will be completed:</u></b> March 13 2013  F441 POC accepted 3/13/13 MHIqams RN   PWC	

*WJB*

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F 441	<p>Continued From page 43</p> <p>#4's bed. As the LNA utilized each new washcloth and washed Resident #148, the LNA placed each soiled cloth at the foot of the residents bed on the blue bed spread. It was observed when the aide removed the wet, soiled cloths from the bed, he/she did not remove the blue bedspread.</p> <p>Per interview with a facility LNA on 2/14/13 at approximately 10:30 AM, he/she confirmed that he/she placed wet, soiled wash cloths on the residents clean bed spread and confirmed that he/she did not remove the bedspread after. The LNA indicated that he/she was trained to place soiled wash cloths on the bed and had just forgotten to remove the bed spread.</p> <p>Per interview with the Infection Control Nurse on 2/14/13, he/she indicated that staff was trained to place soiled linen on the foot of the bed after use. The Infection Control Nurse confirmed that not changing the blue bed spread was an infection control issue and that the expectation of staff is that the bedspread be removed and replaced with a clean one.</p> <p>2. Per observation on 02/11/13 at 1:58 P.M. of a wound dressing change for Resident #107, the staff nurse breached infection control practice .</p>	F 441		

*WSP*

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F 441	<p>Continued From page 44</p> <p>The physician order dated 01/10/13 states - -"change dressing qd [every day] or q3d [every three days] as drainage decrease PRN irrigate w/ safe cleans or NS [normal saline] pack w/ Aquacell, cover w/ ABD pad wrap w/ king/curlex ACE wrap from toes to knee". During the dressing change the nurse cleaned the wound bed with a normal saline gauze from the inside of the wound bed to the outer margins and back into the wound bed.</p> <p>Per interview the Infection Control Nurse (ICN) on 01/13/13 at 2:55 P.M. stated the staff nurse should irrigate the wound and not rub the wound especially from a more clean area to a less area and then back into the wound bed. The ICN confirmed that the staff nurse breached infection control practice.</p> <p>3. Per observation on 2/13/2013 at 4:30 PM soiled linen was noted to be on the floor at the foot of the bed in room 10. In an interview at that time, two LNAs (Licensed Nursing Assistants) present in the room confirmed that the linen was soiled and was on the floor of the resident's room. They further confirmed that placing soiled linen on the floor is not the accepted practice. LNA #1 confirmed that linen is to be placed in a plastic bag or immediately removed from the room.</p>	F 441		
F 514 SS=E	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and</p>	F 514	<p><u>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>Resident # 96 was not affected by these alleged deficient practices. The resident is no longer on 15 minute checks. The resident's fluid intake via a gastrostomy tube is being recorded and the 5ml flushes are now included in the total intake.</p>	

*Wes*

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F 514	<p>Continued From page 45 systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide consistent, accurate documentation and failed to assure information in the clinical record is readily accessible for 2 of 24 Stage 2 sampled residents (Resident #96 &amp; Resident #112). Findings include:</p> <p>1. Per record review on 2/13/2013 a progress note written on 12/19/2012 indicated that Resident #96 was on safety observation checks every 15 minutes. This was verified with the writer of the note on 2/13/2013 at 8:54 AM.</p> <p>Per observation at 9:00 AM the safety observation check list had not been completed since 7:00 AM and this was verified at 9:18 AM with the LPN on duty. The LPN stated that the resident has been on 15 minute safety checks for a long time, because s/he had talked about harming him/her self, but s/he could not recall how long s/he had been on them. S/he also verified that the LNA fills in the form each time they check on the resident and s/he knows they check on him/her and s/he further indicated that the form should be filled out every 15 minutes.</p>	F 514	<p>Resident # 112 was not affected by this alleged deficient practice. The residents ADLs continue to be inputted into the kiosk. All documentation prior to the initiation of the electronic record is available in the hard copy of the resident's record.</p> <p><b><u>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:</u></b></p> <p>All residents requiring 15 minute checks and/or documentation into the kiosk have the potential to be affected by this alleged deficient practice.</p> <p><b><u>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:</u></b></p> <p>Nursing staff will be re-educated in the procedure for recording 15 minute checks as per policy.</p> <p>Nursing staff will be re-educated on the procedure for inputting all fluid intake of those residents on Intake and Output.</p> <p>Nurses including management staff will be educated on retrieving information related to the residents ADL from the electronic record when requested.</p>	
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F 514	<p>Continued From page 46</p> <p>On 2/13/2013 at 2:30 PM it was further verified with the LPN that the 15 minute observation safety check list had not been completed as expected.</p> <p>2. Per record review of Resident #96 on 2/13/2013, staff failed to accurately document the total amount of intake the resident was receiving via enteral feeding and flushes. The physician had ordered the resident to receive Glucerna 1.2 via gastrostomy tube feeding (G-Tube), and to have nothing by mouth. It further indicates that the resident is to receive Glucerna 1.2 via GTube at 80 milliliters(ml)/hour for 8 hours from 10:00 PM to 6:00 AM and Glucerna 1.2 boluses of 200 ml 4 times daily. Physician orders also specify to administer water flushes as follows: 150 ml every 6 hours, 25 ml automatic flush per hour during night enteral feeding, 10 ml before and after each medication pass, 50 ml water flush before and after each bolus and a 5 ml flush between each medication. The LPN verified that there are three medication administration times for this resident and there a total of 23 medications administered during these times. The total nutritional intake and flushes are 2615 ml per day with the intake records from January 1 to February 12, 2013 indicating that requirement was only met once. The LPN verified that the intake record for Resident #96 is done by the nurse on duty. The medication administration record reveals that documentation had not been completed by nursing staff for the 5 ml flush between each medication and this was verified by the LPN on duty.</p> <p>3. Per record review, Resident #112's MDS Quarterly review assessment on 07/25/2012</p>	F 514		
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F 514 Continued From page 47  
listed the resident as having "occasional incontinence". The care plan dated 07/26/12 states "occasional incontinence of UA has had 2 episode in 1 week," with interventions of "assist with toilet care if needed, provide and encourage adequate fluids, monitor I&O-PRN." Per interview on 02/13/13 at 3:00 P.M. LNA staff were unable to show the nurse surveyor the electronic LNA flow sheets from the time period of the Quarterly assessment of 07/25/2012. They stated that the put the information of intake and incontinence or toileting into the electronic system known as the kiosk. Per interview on 02/13/13 at 5:14 P.M. the Unit Manager stated "I am not sure if I can check the kiosk or not but if the information is not in the chart, I just go to [the MDS coordinator] to check, I wasn't aware [s/he] was incontinent". MDS coordinator was not available to provide the electronic LNA flow sheet.

Per interview later that day, the DNS stated that the electronic LNA flow sheets shows services provided and is part of the resident's record. S/he stated State surveyors should have accesses to that report and stated "will have to check with corporate to get that for you". S/he confirmed that the resident's record did not have sufficient information of the services provided and was not readily accessible.

F 514

**4. How 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?**

Random audits of all 15 minute checks will be completed 5days per week x 90 days

Random audits of Intake and Output documentation will be done Everyday x 90 days

Nurses will be audited for the ability to retrieve information from the electronic medical record 1x per week x 90 days.

**5. Dates Corrective Action will be completed:**

DNS/Designee will be responsible for compliance.

March 13 2013

F514 POC accepted 3/13/13  
M Higgins RN | Pmc

*[Handwritten signature]*