



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

September 13, 2010

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 complaint investigation conducted on August 24, 2010. 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,

A handwritten signature in cursive script that reads "Pamela M. Cota".

Pamela M. Cota, RN
Licensing Chief



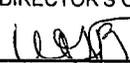
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2010
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 C 08/24/2010
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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
F 000	INITIAL COMMENTS	F 000		
F 280 SS=D	<p>The Division of Licensing and Protection conducted an unannounced onsite complaint investigation on 8/24/10.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to revise the plan of care to reflect the current needs of one applicable resident in the sample. (Resident #1) Findings include:</p> <p>Per record review, the Care Plan (CP) for Resident # 1 was not revised to include specific</p>	F 280	<p>F280</p> <p>What corrective action will be accomplished for those residents found to have been affected by deficient practice?</p> <p>Resident #1 careplan was updated to include specific approaches and interventions to prevent recurrent aspiration.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Residents that are readmitted with possible aspiration risk are at risk for nutritional careplan not being updated.</p> <p>What measures will be put in place or what systemic changes will be made to ensure the deficient practice does not recur?</p> <p>Residents readmitted with possible aspiration risk will have a chart /careplan review on admission with a followup review at the 7 and 14 days or if a concern for aspiration is identified.</p> <p>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</p> <p>An audit tool has been developed to ensure that on readmission nutritional careplans are updated with specific approaches to prevent recurrent aspiration.</p> <p>These audits will be done weekly x 4, monthly x 4 then quarterly x 1 with results reported to the QAA committee.</p> <p>Nursing staff will receive education on readmission care plans being updated with appropriate intervention on readmitted residents identified as aspiration risks..</p> <p>The date corrective action will be completed. 9/24/10</p> <p>Responsible: Unit managers ADNS or other designee</p>	<p>RECEIVED Division of SEP 09 10 Licensing and Protection</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 9.7.10
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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.

F280 POC Accepted 9/13/10 A. Knorr RN / P. Motta RN

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F 280	Continued From page 1 interventions to prevent choking and aspiration during feeding. Per record review, Nurses Notes (NN) written on 7/7/10 on the 7AM - 3PM shift describe an incident which occurred while Resident #1 was being fed the evening meal. The resident was "noted to have white mucous of foamy nature after starting to be fed" and was "coughing up some but unable to speak due to throat being full." On 7/8/10 the NN describe the resident "just letting it run out of [his/her] mouth" with attempts at feeding, and the resident was subsequently transferred and admitted to the hospital that afternoon. The 7/10/10 hospital Discharge Summary describes the resident as having experienced "transient hypoxia and possible aspiration." The current Nutrition Care Plan was not revised after the hospital admission and discharge to include specific approaches and interventions to prevent recurrence of aspiration.	F 280	What corrective action will be accomplished for those residents found to have been affected by deficient practice? The order for CBC 3xweekly was removed from the resident #1 medical record with permission from the residents physician 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 who have orders for blood work and have the same last names are at risk What measures will be put in place or what systemic changes will be made to ensure the deficient practice does not recur? Residents with the same last name will have "same name" alert stickers placed on their charts. Charts with same last name will be reviewed for accuracy at changeover with a triple check. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? An audit tool has been developed to review blood work orders on resident charts that have the same last name to ensure these orders are appropriate orders for these identified residents at risk. Audits will be conducted weekly x 4, monthly x 4 then quarterly x 1. Results of these audits will be reported to QAA Nursing staff will receive education on monitoring for accurate orders related to bloodwork on residents with the same last name. The date corrective action will be completed. 9/24/10 Responsible: Nurse managers Staff Educator ADNS or other designee	
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to ensure that the physician reviewed the resident's total plan of care, including medications and treatments, at each visit for one applicable	F 386		

F386 POL Accepted 9/13/10 A. Knorr RN / P. MacArthur RN

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F 386	Continued From page 2 resident in the sample. (Resident #1) Findings include: Based on record review, signed Physician's Orders for Resident #1 included orders for laboratory testing and treatment that were not medically indicated. Per record review, Physician Orders written and signed for Resident #1 for the months of June, July and August 2010 include an order for "CBC (Complete Blood Count) three times a weekly (sic) at dialysis." Confirmed with the Unit Manager on 8/24/10 at 1:15 PM, the resident does not require and is not receiving dialysis or three times weekly CBC testing, and stated "That is an error in the orders." Record review confirmed that the resident has not had dialysis or CBC testing three times a week	F 386	What corrective action will be accomplished for those residents found to have been affected by deficient practice? The order for CBC 3xweekly was removed from the resident #1 medical record with permission from the residents physican 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 who have orders for blood work and have the same last names are at risk. What measures will be put in place or what systemic changes will be made to ensure the deficient practice does not recur? Residents with the same last name will have "same name" alert stickers placed on their charts. Charts with same last name will be reviewed for accuracy at changeover with a triple check.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE 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 systematically organized. 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. This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to maintain accurate clinical records on one resident	F 514	How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? An audit tool has been developed to review blood work orders on resident charts that have the same last name to ensure these orders are appropriate orders for these identified residents at risk. Audits will conducted weekly x 4, monthly x 4 then quarterly x 1. Results of these audits will be reported to QAA Nursing staff will receive education on monitoring for accurate orders related to bloodwork on residents with the same last name. The date corrective action will be completed. 9/24/10 Responsible: Nurse Managers Staff Educator ADNS or other designee	

F514 POC Accepted 9/13/10 A. Knorr RN / Pmcoturn

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F 514	<p>Continued From page 3 in the applicable sample. (Resident #1) Findings include:</p> <p>Based on record review, the Physician's Orders for Resident #1 include orders for laboratory testing and treatment that were not medically indicated and written in error. Per record review, Physician Orders written and signed for Resident #1 for the months for June, July and August 2010 include an order for "CBC (Complete Blood Count) three times a weekly (sic) at dialysis." Confirmed with the Unit Manager on 8/24/10 at 1:15 PM, the resident does not require and is not receiving dialysis or three times weekly CBC testing, and stated "That is an error in the orders." Record review confirmed that the resident has not had dialysis or CBC testing three times a week.</p>	F 514		
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