

Division of Licensing and Protection
103 South Main Street
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

September 18, 2015

Mr. Randy Crowder, Administrator
Bennington Health & Rehab
2 Blackberry Lane
Bennington, VT 05201-2300

Dear Mr. Crowder:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 19, 2015**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief



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

PRINTED: 09/01/2015
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 08/19/2015
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)

F 000 INITIAL COMMENTS

F 000

An unannounced on site complaint investigation was conducted by the Division of Licensing and Protection on 8/18/15 and 8/19/15. There was a regulatory finding.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=B PROFESSIONAL STANDARDS

F 281

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review the facility failed to provide services that meet professional standards of quality surrounding the documentation process for one resident (Resident #1). Findings include:

Per interview on 8/18/15 at 2:05 PM with a Staff Nurse on North Wing fifteen 15 minute checks were to be done and documented every 15 minutes. He/she stated these checks were documented on a safety check sheet which was kept on a clipboard at the nurses' station. Per record review on 8/18/15 at 2:10 PM for Resident #1, who was care planned for 15 minute checks, the 1415, 1430, 1445, 1500 checks were signed off as complete prior to the actual time the checks were to be done. The Facility Administrator confirmed at this time that the fifteen minute checks for Resident #1 were signed off prior to the actual time the check was to be done. He/she further stated that fifteen minute checks are to be done every fifteen minutes and signed for at the time they are done.

F281 483.20(k)(3)(i)

1. Resident #1 had no negative effect as a result of the alleged deficient practice
2. Resident requiring every 15 minute checks have the potential to be affected by the alleged deficient practice
3. Residents currently requiring 15 minute checks have been reviewed for continued need and discontinued as appropriate
4. Education will be provided to staff regarding the appropriate method of documentation of 15 minute checks
5. Weekly audits will be conducted by the DNS or designee to monitor the effectiveness of the plan
6. Results of the audits will be reported at the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits
7. Corrective action will be completed by 09/18/2015

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

Randy Aude 9/14/15

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.

F281 POC accepted 9/17/15 DWIKAWAKERN/PMU

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

PRINTED: 09/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 476027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/19/2015
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)

F 281 Continued From page 1

F 281

The Lipincott Manual of Nursing Practice, Seventh Edition, 2001, pg 19.
'Failure to make prompt, accurate entries in a patient's medical record.'