

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

October 15, 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 **September 22, 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: 09/28/2015
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 09/22/2015
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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)	(X6) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews, the facility failed to provide services in accordance with a written care plan surrounding safety interventions for a resident, Resident #1, who was at high risk for falls. Findings include:</p> <p>Resident #1 was admitted to the facility on 8/21/15 from an acute care hospital following surgical repair for a fractured left femur. Resident # 1 has diagnosis to include cognitive communication deficit and dementia. Resident #1 had sustained a fall at home in July that resulted in a fracture left femur and joint replacement, while at another facility, s/he sustained another injury to the left femur, which resulted in another fracture. The care plans dated 8/21/15 for Resident #1 state that s/he is at the facility for rehab due to the hip fracture and that s/he is alert with dementia and that s/he is in a gerichair and needs assistance with activities of daily living. One of the interventions is to make sure a TABS alarm is in place. During interview</p>	F 282	<p>F 282 483.20(k)(3)(ii)</p> <ol style="list-style-type: none"> 1. Resident #1 is no longer in the facility. 2. Residents that require safety Intervention have a potential to be affected by the alleged deficient practice. 3. Education will be provided to the staff regarding following care plan intervention and appropriate placement of tab alarms. 4. Weekly random audits will be conducted by the DNS or designee to monitor effectiveness of the plan. 5. Results of the audits will be reported at the QAA committee monthly for 3 months at which time the QAA committee will determine further frequency of the audits. 6. Corrective action will be completed by 10/21/2015. <p>F282 POC accepted 10/15/15 BB ctk/RN/PMK</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Randy [Signature]</i>	TITLE Executive Director	(X6) DATE 10/14/15
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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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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 282	Continued From page 1 with direct care staff, it was indicated by Licensed Nursing Assistant (LNA's) that Resident #1 was to have a TABS on at all times, to be in a gerichair, 2 person assist hoier lift and be in a low bed. Resident #1 sustained a fall on 9/4/15 and was found on the floor beside her bed. On 9/22/15 at 3:32 PM per interview with LNA that found Resident #1 on the floor stated that s/he did not have the TABS alarm on at the time of the fall. It was on the chair and it was supposed to be on with him/her at all times. S/he was lying in the bed sleeping at the beginning of the shift and it seems as if s/he had tried to get out of bed. The Director of Nursing confirmed on 9/22/15 at 8:37 PM that the TABS is part of the care plan and that it should have been on the resident.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to provide adequate supervision and assistance devices to prevent accidents for a resident, Resident #1, who was at high risk for falls. Findings include: Resident #1 was admitted to the facility on 8/21/15 from an acute care hospital following	F 323	<p>F 323 483.25(h)</p> <ol style="list-style-type: none"> 1. Resident #1 is no longer in the facility. 2. Residents that require safety intervention have a potential to be affected by the alleged deficient practice. 3. Education will be provided to the staff regarding following care plan intervention and appropriate placement of tab alarms. 4. Weekly random audits will be conducted by the DNS or designee to monitor effectiveness of the plan. 5. Results of the audits will be reported at the QAA committee monthly. 6. Corrective action will be completed by 10/21/2015. 	

F323 POC accepted 10/15/15 BDonnell/PME
fmc

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F 323	Continued From page 2 surgical repair for a fractured left femur. Resident # 1 has diagnosis to include cognitive communication deficit and dementia. Resident #1 had sustained a fall at home in July that resulted in a fracture left femur and joint replacement, while at another facility, s/he sustained another injury to the left femur, which resulted in another fracture. The care plans dated 8/21/15 for Resident #1 state that s/he is at the facility for rehab due to the hip fracture and that s/he is alert with dementia and that s/he is in a gerichair and needs assistance with activities of daily living. One of the Interventions is to make sure a TABS alarm is in place. During interview with direct care staff, it was indicated by Licensed Nursing Assistant (LNA's) that Resident #1 was to have a TABS on at all times, to be in a gerichair, 2 person assist hooyer lift and be in a low bed. Resident #1 sustained a fall on 9/4/15 and was found on the floor beside her bed. On 9/22/15 at 3:32 PM per interview with LNA that found Resident #1 on the floor stated that s/he did not have the TABS alarm on at the time of the fall. It was on the chair and it was supposed to be on with him/her at all times. S/he was lying in the bed sleeping at the beginning of the shift and it seems as if s/he had tried to get out of bed. The Director of Nursing confirmed on 9/22/15 at 8:37 PM that the TABS is part of the care plan and that it should have been on the resident.	F 323		
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