

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

April 9, 2014

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

Dear Ms. Anair:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 19, 2014**. 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: 03/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/19/2014
NAME OF PROVIDER OR SUPPLIER CENTERS FOR LIVING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 180 HOSPITAL DRIVE 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 000	INITIAL COMMENTS	F 000	<p><i>The facility submits the following information and corrective action plans to demonstrate the facility's compliance with all the rules and regulations. This plan of correction is filed to comply with the requirements set forth by CMS and does not constitute an admission that the alleged deficiencies did in fact exist.</i></p> <p><u>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>Since the focus survey, residents # 1, 2, and 3 have been seen by Social Services and have had an updated psychosocial assessment. Resident #4 has been discharged from the facility.</p>	
F 250 SS=E	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, lack of medical documentation and staff interview, the facility failed to provide medically related social services to maintain the highest practicable mental and psychosocial well-being for 3 of 5 of residents reviewed. Findings include:</p> <p>1.) Per record review, on 11/8/13, Resident #2 bumped his/her wheelchair into that of Resident #1 and then grabbed his/her arm, leaving a bruise, and at this time Resident #1 grabbed the hair of Resident #2. Review of social and nurse progress notes, there is no documentation to support that Resident #1 was seen by social services until 11/19/13, 11 days following the incident and did not follow up with Resident #1 after to determine psycho-social well-being. There were no social service notes for Resident #2 to address the well-being after having his/her hair pulled. Confirmation was made by the DON,</p>	F 250		

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

TITLE

(X6) DATE

[Signature] Administrator 04/08/2014

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.

PMU

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F 250	Continued From page 1 after reviewing that documentation not present at 3:15 PM Per interview with social worker on 3/19/14 at 9:45 AM regarding documentation following a resident to resident altercation, the residents are seen immediately following notification of the altercation. Per social worker statement, h/she would visit and discuss what happened, what triggered and what their feelings are regarding the altercation. H/she further indicated that regardless of orientation, observation of emotional status would be done. Confirmation made at 10:29 by social worker that documentation not present to support evidence of assessing the psycho-social well-being of Resident #1. H/she further confirmed that Resident #1 was not seen immediately. 2.) Per record review of Resident #2 presents with an altercation on 11/8/13 with Resident #1, in which Resident #1 pulled the hair of Resident #2 after h/she bumped into him/her with their wheelchair. Review of social service and nursing progress notes presents without documentation of an assessment regarding the impact the altercation had on them. Reviewed with DON at 3:15 PM and confirmation made that documentation not present. Per interview with social worker on 3/19/14 at 9:45 AM regarding documentation following a resident to resident altercation, the residents are seen immediately following notification of the altercation. Per social worker statement, h/she would visit and discuss what happened, what triggered and what their feelings are regarding the altercation. H/she further indicated that regardless of orientation, observation of emotional status would be done. Confirmation made at 10:29 by social worker that documentation not present to support evidence of assessing the psycho-social well-being of	F 250	<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> Since the focus survey, the facility has identified those residents that had the potential for psychosocial harm following any unintended events. The identification was done based on previous documentation from reports to the Division of Licensing and Protection. The resident's records' were evaluated for any potential psychosocial disturbances. Assessments were completed with updated documentation in the residents' medical records. <u>3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?</u> The Abuse, Neglect and Exploitation policy was reviewed.	

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F 250	Continued From page 2 Resident #2. 3.) Per record review, Resident #1 was struck by Resident #2 during lunch on 12/22/13, causing Resident #1 to have bruising to top of left hand. Per review of social service notes reveals that Resident #1 was seen by social services, but there is no documentation regarding psychosocial well-being or discussion of the occurrence. Per interview with social worker on 3/19/14 at 9:45 AM regarding documentation following a resident to resident altercation, the residents are seen immediately following notification of the altercation. Per social worker statement, h/she would visit and discuss what happened, what triggered and what their feelings are regarding the altercation. H/she further indicated that regardless of orientation, observation of emotional status would be done. Confirmation made at 10:29 by social worker that documentation not present to support evidence of assessing the psycho-social well-being of Resident #1. 4.) Per record review on 3/19/14, Resident #3 was grabbed by Resident #1 on the afternoon of 11/12/13, causing Resident #1 to have a bruise to the left wrist. Social services saw Resident #3 on 11/15/13, three days following the incident. The documentation does not support evidence of assessing for psycho-social well-being in regards to the incident. Per interview with social worker on 3/19/14 at 9:45 AM regarding documentation following a resident to resident altercation, the residents are seen immediately following notification of the altercation. Per social worker statement, h/she would visit and discuss what happened, what triggered and what their feelings are regarding the altercation. H/she further	F 250	Changes were made to the electronic medical record to include an automatic trigger for a Social Services consult and a Psychosocial Assessment when an unintended event occurs that results in a Division of Licensing and Protection report. The consult will be done to ensure that the resident's psychosocial well-being is maintained with documentation thereof. Education completed with Nursing and Social Services to review F-tag 250 regulations and system changes to ensure that resident and/or patient psychosocial well-being is maintained. <u>4. How the corrective action will be monitored to ensure the deficient practice does not reoccur, i.e., what quality assurance program will be put into place?</u> For the next 90 days, the DNS and/or designee will audit 100% of resident and or patient unintended events that result in a report to DLP. This audit	

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F 250	Continued From page 3 indicated that regardless of orientation, observation of emotional status would be done. Confirmation made at 10:29 by social worker that documentation not present to support evidence of assessing the psycho-social well-being of Resident #3 h/she further confirmed that Resident #4 was not seen immediately.	F 250	will confirm psychosocial assessments are completed and documented by nursing and social services. The audits will be reported monthly at the DLR Safety-Quality Committee meeting <u>5. Dates of corrective action will be complete:</u> Friday April 11, 2014 F250 POC accepted 4/8/14 BBortell RN PMC	