

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

September 13, 2012

Ms. Penny Bruso, Administrator
Centers For Living And Rehab
160 Hospital Drive
Bennington, VT 05201

Dear Ms. Bruso:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 23, 2012**. 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

RECEIVED
Division of
SEP 12 12

PRINTED: 08/27/2012
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 08/23/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER CENTERS FOR LIVING AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 160 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		
F 280 SS=D	<p>An unannounced on-site complaint investigation was initiated on 7/5/2012 by The Division of Licensing and Protection and completed on 8/23/12. There were regulatory findings as follows:</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 record review and staff interview the facility failed to revise the comprehensive plan of care for 1 resident (Resident #1) to reflect the residents current medical status and specific goals and interventions to address the residents</p>	F 280	<p>F280: <u>Corrective Action:</u> Resident #1 no longer resides in the facility.</p> <p><u>Other Residents:</u> Recently admitted patients/residents are at risk.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> Care plans of patients/residents admitted since 9/1/12 have been reviewed. 9/7/12 Subacute care coordinator will be re-educated on individualized care planning based on comprehensive assessments. 9/19/12 All care coordinators/designee will provide a copy of the revised care plan to appropriate nurse manager/designee for review following each comprehensive assessment. 9/14/12 Nurse manager/designee will audit the care plan revisions to ensure care plan reflects appropriate patient-specific interventions. (see Exhibit A) 9/14/12 <p><u>Ongoing Monitoring:</u> Nurse manager/designee will provide copy of audits weekly to DNS/designee. 9/14/12</p> <p>DNS/designee will report audit results at Quality/Safety Committee meeting monthly x 3 months. 9/25/12</p> <p><i>F280 POC accepted 9/13/12 Maulinan RN/PMC</i></p>	

LABRATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Darryl Romo DHA</i>	TITLE Administrator	(X6) DATE 9/7/12
--	------------------------	---------------------

A 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.

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

PRINTED: 08/27/2012
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 08/23/2012
NAME OF PROVIDER OR SUPPLIER CENTERS FOR LIVING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 160 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 280	Continued From page 1 specific needs. The findings include: 1. Per review of the medical record on 7/5/12, Resident #1 was admitted to the facility for short term rehabilitation and pain management status post a hospital stay for surgery to Resident #1's right knee on 4/24/12. Per review of the admission pain assessment dated 4/25/12, Resident #1 indicated to staff that he/she is in frequent pain, that the pain interferes with his/her ability to perform day to day activities and interferes with his/her sleep over the past 5 days. The assessment also indicates that analgesia (pain medication) and ice make the pain better and that ambulation, exercise and positioning all make the pain worse. Per review of the Braden Assessment completed on 4/25/12, Resident #1 had no sensory deficits that would impede his/her's ability to feel/voice pain or discomfort. Per review of the cognitive assessment Resident #1 was alert and oriented and able to make his/her needs known. Per review of the daily pain assessments on 5/3, 5/7, 5/8, 5/9, 5/10 and 5/11, Resident #1 indicated to his/her pain level to be 5, and the pain was located in the right knee, the pain assessments for 5/3, 5/7, 5/8, 5/9, 5/10 and 5/11 indicate that pain medication was given and there was no change to Resident #1's pain. Per review of the medical record there was no evidence that the physician was notified that Resident #1 was having unrelieved pain and there was no documentation that indicated that any interventions were utilized to minimize Resident #1's pain. Per review of the comprehensive care plan dated 4/25/12 and titled; "Alteration in comfort related to pain, arthritis and spot operative status", the	F 280		

AB 9/17/12

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

PRINTED: 08/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475029	(X2) MULTIPLE CDSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/23/2012
NAME OF PROVIDER OR SUPPLIER CENTERS FOR LIVING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 160 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	PRDVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 2 nurses were to "complete a pain screen at least daily and administer pain medications as ordered, monitor/record medication effectiveness". Per the plan of care dated 5/2/12 pain does not interfere with rehabilitation participation. Per interview with the Director of Nursing on 7/5/12 the plan of care titled "Alteration in comfort related to pain, arthritis and post operative status" and dated 4/25/12 was reviewed with the DNS, he/she confirmed that the plan of care did not reflect that Resident #1 had pain frequently that at times interfered with the residents sleep patterns and was difficult to control at times, that ice and analgesia were effective for pain control, that movement, ambulation and positioning increased resident's pain, or that Resident #1 requested to receive pain medication prior to therapy services. Per interview on 7/5/12 with the DNS and facility Administrator they confirmed that no specific interventions and goals were identified to meet the specific pain management needs for Resident #1 and interventions and goals to prevent unrelieved pain for Resident #1.	F 280	F309: Corrective Action: Resident #1 no longer resides in the facility Other Residents: All residents/patients with pain are at risk. Patients/residents with care plans for potential for pain and/or pain were reviewed/revised as needed. Systemic Changes: 1. Pain management policy reviewed and revised 9/7/12 2. Pain re-education will be provided to RNs/LPNs by staff educator/designee. 9/25/12 3. All residents/patients that triggered for PRN pain assessments will be audited weekly by Clinical Systems specialist/designee for appropriate interventions and follow-up when needed. (see Exhibit B) 9/14/12	9/19/12
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the	F 309	Ongoing Monitoring: Weekly audits will be provided to DNS/designee by Clinical System Specialist. 9/14/12 DNS/designee will report audit results at Quality/Safety Committee meeting monthly x 3 months. 9/25/12 F309 POC accepted 9/13/12 McCullin RN/ Pmc	9/14/12 9/25/12

PB
9/17/12

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

PRINTED: 08/27/2012
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 08/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CENTERS FOR LIVING AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 160 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 309	<p>Continued From page 3</p> <p>facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being for one resident (Resident #1). The findings include:</p> <p>1. Per review of the medical record on 7/5/12, Resident #1 was admitted to the facility for short term rehabilitation and pain management status post a hospital stay for surgery to Resident #1's right knee on 4/24/12 . Per review of the admission pain assessment dated 4/25/12, Resident #1 indicated to staff that he/she is in frequent pain, that the pain interferes with his/her ability to perform day to day activities and interferes with his/her sleep over the past 5 days. The assessment also indicates that analgesia (pain medication) and ice make the pain better and that ambulation, exercise and positioning all make the pain worse. Per review of the Braden Assessment completed on 4/25/12, Resident #1 had no sensory deficits that would impede his/her's ability to feel/voice pain or discomfort. Per review of the cognitive assessment Resident #1 was alert and oriented and able to make his/her needs known.</p> <p>Per review of the physician's orders dated 4/24/12, Resident #1 was to receive 1 Percocet tablet by mouth for a pain level of 5-7 as needed. Per review of the pain assessment for 5/2/12 at 8:45 AM, Resident #1 indicated that he/she had a pain level of 5 out of 10 in his/her right knee, he/she was given Percocet at 8:45 AM and at 9:45 AM the nurse documents that Resident #1 still has pain of a 5/10 and that Resident #1's pain is unchanged and will continue to observe and rest. Per review of the nurses notes, there was no</p>	F 309		
-------	---	-------	--	--

AB
9/7/12

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

PRINTED: 08/27/2012
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 08/23/2012
NAME OF PROVIDER OR SUPPLIER CENTERS FOR LIVING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 160 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 309	<p>Continued From page 4</p> <p>evidence that any interventions pharmacological or non pharmacological were attempted to try to alleviate Resident #1's pain. Per review of the daily pain assessments on 5/3, 5/7, 5/8, 5/9, 5/10 and 5/11, Resident #1 indicated to his/her pain level to be 5, and the pain was located in the right knee, the pain assessments for 5/3, 5/7, 5/8, 5/9, 5/10 and 5/11 indicate that pain medication was given and there was no change to Resident #1's pain level it remained at a 5 and the documentation by the nurse indicated to observe Resident #1. Per review of the medical record there was no evidence that the physician was notified that Resident #1 was having unrelieved pain and there was no documentation that indicated that any interventions were utilized to minimize Resident #1's pain.</p> <p>Per interview with the Director Of Nursing (DNS) on 7/5/12 at 12:16 PM, he/she indicated that the expectation for pain management for residents is that the nurses assess a resident a minimum of every four hours for pain and that all interventions pharmacological and non-pharmacological need to be utilized to control a resident's pain and when not effective the physician be notified. Per review of the pain assessments with the DNS on 7/5/12 at the DNS confirmed that on 5/2, 5/3, 5/7, 5/8, 5/9, 5/10 and 5/11, Resident #1 had pain that was not relieved and no interventions were utilized to minimize the resident's pain and the physician was not notified of Resident #1's unrelieved pain.</p>	F 309			

PB
9/7/12

Centers for Living and Rehabilitation
Performance Improvement Audit

Exhibit B

Standard of Practice: Pain Re-Assessment Audit

Date: _____

Number of Residents Reviewed: _____

Reviewer: _____

#	CRITERIA	YES	NO
1.	All residents/patients assessed for pain were re-assessed? If no, see below.		
2.	On re-assessment all residents with continued pain, at 5 or greater, had further interventions documented? If no, see below.		
3.	On re-assessment all residents with continued pain, despite further interventions had M.D. and family notification, if appropriate? If no, see below.		
Number of Residents needing action items:			
Corrective Action:			
	Resident Name:	Action taken:	

- Goal:
- 100% = residents/patients reporting pain were re-assessed
 - 100% = residents/patients re-assessed with continued pain of 5 or greater had further inventions
 - 100% = residents/patients with continued pain, despite further interventions had appropriate M.D. and family notifications

Centers for Living and Rehabilitation
Performance Improvement Audit

Exhibit A

Standard of Practice: Comprehensive Care Plan Audit

Date: _____

Number of Residents Reviewed: _____ Reviewer: _____

#	CRITERIA	YES	NO
1.	Were all care area assessments addressed in the Care Plan? If no, see below.		
2.	Were the interventions specific to current resident needs? If no, see below.		
Number of Residents needing action items:			
Corrective Action:			
	Resident Name:	Action taken:	

Goal: 100% = all care area assessments are addressed in Care Plan
100% = all interventions are resident/patient-specific