

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

January 5, 2016

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 **December 16, 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: 12/22/2015
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 12/16/2015
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NAME OF PROVIDER OR SUPPLIER CENTERS FOR LIVING AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 160 HOSPITAL DRIVE BENNINGTON, VT 05201
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F 000	INITIAL COMMENTS	F 000		
F 323 SS-E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that the resident environment remained as free from accident hazards as possible related to storage of potentially hazardous chemicals in 1 resident room (Resident #175) and safety and fall risk issues related to a lack of access to light switches and low lighting levels in 8 single resident rooms in the facility (Rooms A143, A144, A146, A148, S141, S142, F118 and F120). Findings include:</p> <p>1. Per observation on 12/14/15 at 1:47 PM, a bottle of isopropyl alcohol was observed on an open shelf in Resident # 175's room. On 12/16/15 at 11:47 AM during a tour with the Nurse Unit Manager (UM), the open bottle of isopropyl alcohol was still present on the open shelf and a 6 oz bottle of nail polish remover was observed on another shelf. Both items were visible,</p>	F 323	<p><u>F 323</u></p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>For patient #175 the patient was agreeable to having the Isopropyl alcohol and the nail polish remover removed and stored at the Nurses station. Also, the MD reviewed the resident's request for the isopropyl alcohol as an ear treatment.</p> <p>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?</p> <p>Environmental safety rounds were conducted on all resident rooms. During the rounds any hazardous chemicals and/or disposable razors found were secured and/or disposed.</p> <p>During the environmental rounds all residents found to be providing self administered treatments were assessed</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature] TITLE: Administrator (X6) DATE: 12/30/2015

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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F 323	<p>Continued From page 1</p> <p>unsecured and accessible to anyone who entered the room. Following the observation, the UM confirmed that there were residents with dementia who wander on the unit and were at risk for accessing the chemicals. S/he reported that Resident #175's family often brought [him/her] self-care products without notifying staff. S/he reported that typically staff LNA's (Licensed Nursing Assistants) would report finding these products to a supervisor but had not done so.</p> <p>Per review, the facility policy, Self Administration of Medications and Treatments (Reviewed 11/24/13) states: III. A. Self-administration of medications or treatments by resident/patient is permitted by a Physician Order ...and [includes] any special instructions B. All medications and treatments for self-administration are kept in a locked box that will be provided to the resident C. The resident/patient must be willing and able to manage the lock and key to the storage box. D. Self-administered medications and treatments will be monitored by the charge nurse.</p> <p>On 12/16/15 at 11:55 AM, the UM and facility Director of Nursing (DON) confirmed that the above policy applied to the isopropyl alcohol and nail polish remover found in Resident #175's room; the UM confirmed that there was no physician order for Resident #175 to use either product for self-treatment and that the facility policy was not followed for safe storage.</p> <p>2. On 12/14/15 at approximately 2:18 PM, it was observed that there was no overhead lighting in rooms # 143 and #146 and no light switch at the entrance to the rooms to turn on the over the bed light (the main source of light in the room other than a night light). The lack of a light switch by the</p>	F 323	<p>and will be managed according to the facility policy.</p> <p>All residents that are known to self administer medications or provide self treatments were reviewed to insure compliance with the facility policy.</p> <p>3. <i>What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?</i></p> <p>The policies for "Self Administration of Medications and Treatments," "Shavers - Electric or Disposal" and "Resident Rights" were reviewed and updated as necessary.</p> <p>Staff was educated on the Policy updates.</p> <p>In the future nail polish remover will be secured in the Medication rooms.</p> <p>All self administered medications will be secured in the patient's room according to the facility policy.</p>

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F 323	<p>Continued From page 2</p> <p>entrance door required the residents to cross a darkened room to access a pull string located on the far side of the over the bed light creating a risk for falls.</p> <p>During a tour of the facility on 12/16/15 at 8:57 AM with the facility maintenance director (FMD), room #143 was observed to be dark and shadowy though the entrance door was open to the hallway lights, the window curtains in the room were open and a night light at the entrance to the room was turned on. The FMD confirmed the above observations at the time of the tour and that the low lighting and lack of access to a light switch (to turn on the over the bed light) when entering the room contributed to a potential safety/fall risk for residents with poor or low vision who would need to cross to the far side of the room to turn on the over the bed light.</p> <p>Although there was a night light in the room, the FMD reported that it used a 25-40 watt appliance type bulb. Per observation, a louvered wall plate covered the night light bulb limiting the illumination to a dim glow that did not reduce the shadows or darkness of the room at the time of the observation. At 9:09 AM room #146 was observed to have the same lighting/light switch set up as room #143; the room was also observed to be dark and shadowy when lit by the night light though window drapes and room door were open. The FMD reported that rooms A144, A148, S141, S142, F118 and F120 also have the same lighting/light switch set up as room 143. The FMD reported that the facility could install a switch by the door for each of the above mentioned rooms to light a ceiling fixture at the entrance way to improve room lighting and resident safety.</p>	F 323	<p>Environmental Safety rounds will be conducted on the resident units to ensure compliance with our policy.</p> <p>Dome lights that are connected to the light switch at the doors will be installed in rooms F118, F120, S141, S142, A144, A148, A143 & A146.</p> <p>4. How will the corrective actions will be monitored to ensure the deficient practice will not recur (i.e.: what quality assurance program will be put into place)?</p> <p>Environmental Safety Rounds audits will be conducted on all resident units weekly x 4 weeks, then monthly x 3 months then randomly.</p> <p>5. The date's corrective action will be completed.</p> <p>January 16, 2016</p> <p>F323 POC accepted 12/30/15 BBorkell RN/pmc</p>	

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F 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure each resident's drug regimen is free from unnecessary medication for 1 of 5 applicable residents (Resident #127). Findings include:</p> <p>Per record review of physician orders on 12/16/15 at 9:16 AM, Resident #127 had the following allergies documented: azithromycin, tramadol,</p>	F 329	<p>F 329</p> <p>1. <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Resident #127's chart was reviewed. It was noted that nurse practitioner met with resident's daughter on 9/10/2014 which included review of resident's allergies. Daughter stated during the meeting that resident had been taking a medication listed on the allergy list without ill effects. Review of documentation indicated that there were no ill effects noted.</p> <p>2. <i>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</i></p> <p>100% of all resident charts were reviewed for drug allergies and addressed as indicated.</p> <p>3. <i>What measures will be put into</i></p>	

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F 329	Continued From page 4 lorazepam, codeine, clonazepam, indomethcin, randidine, trazodone, lisinopril. These allergies were also documented on the top cover and in the front section of the clinical record. The current medication order read, "Xanax (alprazolam) 0.25mg [milligrams] by mouth two times a day as needed for anxiety and agitation". The medication had been prescribed since July 2015. Per review of the Medication Administration Record (MAR) on 12/16/15 at 10:08 AM, the resident was receiving the medication daily and at times twice daily for anxiety and agitation. The medication, Xanax, is a drug that is listed in the same pharmacological drug classification as lorazepam and clonazepam (Nursing Drug Reference Book 2015). Per interview on 12/16/15 at 10:11 AM with the Unit Manager (UM), he/she confirmed that there was no evidence that nursing, the physician or the pharmacist had recognized the resident's allergies to lorazepam and clonazepam. Per record review on 12/16/15 at 9:16 AM pharmacy consults were being conducted monthly, however, there was no evidence that the pharmacist acknowledged the resident's medication allergies to lorazepam and clonazepam. Per interview on 12/16/15 at 12:07 PM with the Consultant Pharmacist, he/she confirmed that he/she was unaware of the resident's allergies to lorazepam and clonazepam.	F 329	place or what systematic changes will you make to ensure that the deficient practice does not reoccur? MD worksheet was updated to include resident's allergies. Medication reconciliation process was updated to include a review of allergies. Education was provided to nursing staff on the medication reconciliation process. 4. How will the corrective actions will be monitored to ensure the deficient practice will not recur (ie: what quality assurance program will be put into place)? Allergy review audits will be conducted weekly x 4 weeks, then monthly for 3 months, then randomly.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428	5. The dates corrective action will be completed. January 16, 2016 F329 POC accepted 12/30/15 BB or all RN/ Pme	

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F 428	<p>Continued From page 5</p> <p>the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility consultant pharmacist failed to report an irregularity to the Attending Physician and Director of Nursing for 1 of 5 applicable residents (#127). Findings include:</p> <p>Per record review of physician orders on 12/16/15 at 9:16 AM, Resident#127 had the following allergies documented: azithromycin, tramadol, lorazepam, codeine, clonazepam, indomethacin, rantidine, trazodone, lisinopril. These allergies were also documented on the top cover and in the front section of the clinical record. The current medication order read, "Xanax (alprazolam) 0.25mg by mouth two times a day as needed for anxiety and agitation". The medication had been prescribed since July 2015. Per review of the Medication Administration Record (MAR) on 12/16/15 at 10:08 AM, the resident was receiving the medication daily and at times twice daily for anxiety and agitation. The medication, Xanax, is a drug that is listed in the same pharmacological drug classification as lorazepam and clonazepam (Nursing Drug Reference Book 2015). Per interview on 12/16/15 at 10:11 AM with the Unit Manager (UM), he/she confirmed that there was no evidence that nursing, the physician or the pharmacist had recognized the resident's allergies to lorazepam and clonazepam. Per</p>	F 428	<p><u>R428</u></p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #127's chart was reviewed. It was noted that nurse practitioner met with resident's daughter on 9/10/2014 which included review of resident's allergies. Daughter stated during the meeting that resident had been taking a medication listed on the allergy list without ill effects. Review of documentation indicated that there were no ill effects noted.</p> <p>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?</p> <p>100% of all resident charts were reviewed for drug allergies and addressed as indicated.</p> <p>3. What measures will be put into place or what systematic changes will</p>		

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F 428	Continued From page 6 record review on 12/16/15 at 9:16 AM pharmacy consults were being conducted monthly, however, there was no evidence that the pharmacist acknowledged the resident's medication allergies to lorazepam and clonazepam. Per interview on 12/16/15 at 12:07 PM with the Consultant Pharmacist, he/she confirmed that he/she was unaware of the resident's allergies to lorazepam and clonazepam.	F 428	<i>you make to ensure that the deficient practice does not reoccur?</i> MD worksheet was updated to include resident's allergies. Medication reconciliation process was updated to include a review of allergies by nursing and the physician. Education was provided to medical director and the consulting pharmacist on pharmacy recommendations and allergy reviews. <i>4. How will the corrective actions will be monitored to ensure the deficient practice will not recur (ie: what quality assurance program will be put into place)?</i> Allergy review audits will be conducted weekly x 4 weeks, then monthly for 3 months, then randomly. <i>5. The dates corrective action will be completed.</i> January 16, 2016 F428 POC accepted 12/30/15 BBortell RN/AME	