

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

January 18, 2012

Mr. Bruce Bodemer, Administrator
Centers For Living And Rehab
160 Hospital Drive
Bennington, VT 05201

Provider #: 475029

Dear Mr. Bodemer:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 7, 2011**. 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, MS
Licensing Chief

PC:ne

Enclosure



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

PRINTED: 12/19/2011
FORM APPROVED
OMB NO. 0938-0391

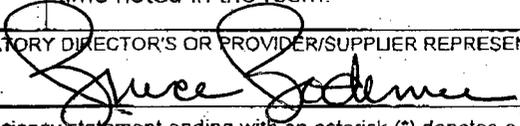
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Division of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	JAN 03 12 Licensing and Protection	(X3) DATE SURVEY COMPLETED 12/07/2011
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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 An unannounced on-site recertification survey was completed by the Division of Licensing and Protection on 12/7/11. The following are regulatory violations.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to provide an activity program to meet the interests and the psychosocial well-being of 1 of 4 applicable residents. (Resident #242) Findings include: 1. Per record review on 12/05/11, Resident #242 was admitted on 11/28/11 with a written care plan for "potential for self isolation related to fatigue; assess interest, assess strength, determine limitations, inform of activities and assist to, be patient, encourage participation, will accept 1 to 1 room visits 3 [times per] week for 5 minutes, will watch TV and read in room for 20 minutes, attend 1 activity of choice and Catholic Mass/ rosary, wants to be comfortable". Per interview on 12/05/11 at 4:02 PM, the Resident stated to the nurse surveyor that "nobody tells me what's going on and not sure what's available, there is no schedule". There was no activity calendar at that time noted in the room.	F 248	F248 - Monthly calendars are placed in resident rooms on or before the first of every month. DNS made rounds and there is an activity calendar in each resident room. Resident activity needs are done based on admission assessment and personal interview. Care plan is done based on said assessment. One-to-one visits are performed based on resident need/desire. A care plan will be developed based on resident needs as they are identified in the admission assessment. Admission assessments are done per MDS guidelines. An audit was done for care plans that stated 1:1 visits and the number of times per week those visits would occur. Residents were re-evaluated for the 1:1 need and the care plan was adjusted accordingly. Documentation	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X8) DATE 12/29/11
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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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F 248	Continued From page 1 Per observation on 12/06/11 at 9:30 AM, an activity calendar was noted on the bathroom door, several feet from the Resident who wears glasses and is unable to get out of bed unassisted nor able to view from bed or chair. In addition, per direct observation on the first two days of survey, the Resident was in the room either in bed or a chair all day. Per review on 12/06/11 at 3:00 PM of the Activity Notes, the Resident received a 1 to 1 room visit on 11/29/11 with no other 1 to 1 visits noted for the rest of the week. The local daily paper was delivered 11/30/11- 12/06/11. Per observation on 12/07/11 at 10 AM although there was a rosary activity, the resident was in bed. Per interview on 12/07/11 at 12:10 PM, the activity Director and assistant stated that the daily paper is delivered by a resident volunteer and that there was only one encounter of a 1 to 1 visit. In addition, the activity assistant stated that s/he informed the resident of the activity by stopping "by the room on my way through [asked from the hallway] if the resident wanted to go to rosary", but confirmed that the resident was not encouraged nor assessed to determine limitations. The Activity Director at that time, confirmed the activities department failed to provide services according to the care plan that met the interests and well being for this resident.	F 248	in the resident medical record will be completed by the activities department at the end of their shift. Both participation and refusal will be documented; random audits will occur weekly to assure care plan is being followed. This will be reported to Safety-Quality Committee for 3 months. F248 POC accepted 1/5/12 Stimmons RN Director RN F250 - Resident #242 is now on Hospice. F 250 There are no further orders or recommendations for Hospice on any other resident in the building. When recommendations are made on the
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250	1/27/12

BB 12/29/11

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F.250	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide medically-related social services to 1 applicable resident who is actively dying, in order to obtain the highest practicable mental and psychosocial well-being. (Resident #242) Findings include: 1. Per record review on 12/05/11, Resident #242 was re-admitted on 11/28/11 with a diagnosis of esophageal obstruction. Per the hospital transfer summary dated 11/28/11 "we would probably recommend a Hospice consult at this time due to the underlying medical condition; Recommendations: I would recommend a Hospice evaluation through the nursing facility". The facility's physician progress note of 11/29/11 states "patient prognosis very poor, wished DNR, if unable to make further gain over the next week will discuss Hospice." Per interview on 12/07/11 at 11:45 AM, a family member stated to the nurse surveyor "I was questioning the facility regarding Hospice...[the resident] has about 4-8 weeks to live, but I was told it had something to do with either Medicare or Medicaid...I'm hoping s/he gets the things s/he needs and gets more help". Per further chart review, the 12/06/11 physician's progress note states "taking liquid nutrition in borderline amounts, unable to tolerate pureed food [secondary] to esophageal obstruction, [s/he] asks about going home but [s/he] is so weak [s/he] requires hoyer lift for transfers...expect gradual decline [secondary] to	F.250	transfer/discharge summaries, a notation will be made on the admission orders for the admitting M.D. to address. Transfer/Discharge summaries will be reviewed with new admissions by the Unit manager, Social Services and the care coordinators. Activities department will continue to do Section F that addresses spiritual needs; Social Services will meet new admissions as soon as possible to address any emotional needs that the resident expresses. Will continue to review Section F audit and follow through on any issues. Section F audit will be reported to Safety-Quality Committee for 3 months. FASD POC accepted 1/5/12 Semmons RN/Prncotaru	1/27/12	

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F 250	Continued From page 3 nutritional or aspiration, continue to ensure comfort above all else". Although the resident has had further decline since admission, there is no Hospice order or documentation of Hospice options. There are notes for palliative care/ comfort measures, however, mostly a medical model (i.e.; no code, no weights, diet, etc) with no mention of emotional or spiritual care. Per interview on 12/07/11 at 1:00 PM, the Social Services Director (SSD) stated the SSD duties include mostly "discharge and admissions and that activities would handle the spiritual needs" but then stated that "the Care Coordinator would handle Hospice issues". The SSD also stated that the resident was on Medicare, and would be needed to switch over to Medicaid (would take about 30 days) to have full Hospice coverage and s/he handed paperwork to the family. Per interview at 1:15 PM the Care Coordinator and Unit Manager stated that their system for palliative/comfort care check list does not address the spiritual or psycho-social needs. When brought to their attention about the family wishes they contacted a priest and confirmed they did not meet the highest practicable mental and psychosocial well-being for Resident #242.	F 250		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315	F315 - Resident #45 currently carries a diagnosis of urinary retention and continues with a foley catheter. Resident #242 had her foley catheter removed on 12/7 at her request. Resident has been incontinent of urine since removal and has required straight catheterization any time residual is >500 ml.	

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F 315	<p>Continued From page 4</p> <p>infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure that 2 of 4 residents with an indwelling Foley catheter had a valid medical justification for use documented in the resident's record and/or received appropriate services and treatment. (Resident #45 and Resident #242) Findings include:</p> <p>1. Per record review and interview, Resident #45 did not receive the appropriate treatment and services to achieve or maintain as much normal urinary function as possible. Per review of the medical chart, Resident #45 had a recent hospital admission for a cardiac procedure and was re-admitted with an indwelling Foley catheter. Per a urology consult on 11/09/11, it directed staff to "1) leave out the catheter; 2) scan post void 1 day a week send me results; 3) re-cath if greater than 500 cc's." Per the post void residual (PVR) sheet obtained by a bladder scan dated 11/09/11, the amount of PVR was 200 cc (cubic centimeters) and on 11/10/11 the amount was 100 cc. Per a nursing note dated 11/11/11 states "telephone call to [primary doctor], resident has burning with urination, get [verbal order] for urine culture and re-sert Foley". There is no medical indication or rationale for the re-insertion, the urologist was not documented as being notified, and the results of the culture did not indicate a urinary infection. The catheter remains in place during the 3 days of survey. Per interview on 12/07/11 at 10:45 AM the Unit</p>	F 315	<p>Residents that currently reside in the facility have an appropriate diagnosis by their primary care M.D. or a urologist.</p> <p>Residents admitted with a foley catheter will have an "Indwelling urinary catheter assessment" (Exhibit #1) completed within 24 hours of admission. Staff will follow the algorithm for keeping the foley catheter or removing it.</p> <p>Staff will be re-educated regarding the new assessment form (not a part of medical record) and the diagnosis allowed for foley catheter use. Assessment forms will be returned to unit manager once completed. Data collected will be reported to Safety-Quality Committee for 3 months.</p> <p><i>F315 POC accepted 11/5/12 SEMmons R/L P. Mestaran</i></p>	1/27/12

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12/29/11*

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F 315	<p>Continued From page 5</p> <p>manager confirmed that the Foley was re-inserted without medical justification and the urologist was not contacted regarding the change in treatment and services.</p> <p>2. Per interview on 12/05/11 at 4:02 PM, Resident #242 stated to the nurse surveyor that s/he did not like having the Foley catheter and s/he was not included in the decision making. Per record review on 12/06/11 at 8:45 AM, Resident #242 was admitted from the hospital on 11/28/11 with a Foley catheter. The resident's transfer record did not have diagnosis nor an order for the catheter but a physician order was obtained on 11/29/11 to remove the Foley catheter. Per the standing orders dated 08/26/10 in the resident's chart, states "may straight cath PRN if resident does not void x 12 hours or if bladder scanner shows a PVR (post void residual) greater than 200 ml, notify the MD if problem persists". Per the Urinary tracking sheet, the resident was voiding on 11/29/11, 11/30/11 and 12/01/11 however, the bladder scan of 12/01/11 had a PVR of 429 ml. In a fax to the physician on 12/01/11 the nurse wrote "may we re-insert the Foley for urinary retention." The physician responded with a order on 12/01/11 "if requires additional straight catheter for urinary retention, insert foley". A nursing note dated 12/05/11 at 5:33 PM states "[resident said] 'I want you to take this catheter out', when explained why, [s/he] stated 'I don't care, I don't like it' - fax sent to MD".</p> <p>Per interview on 12/06/11 at 5:15 PM, the DNS (Director of Nursing Services) said that when the fax to remove the Foley was sent, the covering physician did not know the patient, did not have</p>	F 315		
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F 315	Continued From page 6 the chart available and suggested to contact the primary physician. The DNS confirmed there was no medical justification in the chart at that time and the resident did not participate in the plan of care.	F 315		
F 329 SS=D	<p>483.25(l) 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 record review and staff interview, the facility failed to ensure that 1 of 10 residents in</p>	F 329	<p>F329 - The oxycodone order for resident #45 has been revised to include a range and an indication for use.</p> <p>An audit was completed for PRN pain medications to assure that there was a range, if applicable, and an indication for use.</p> <p>The Medical Director of CLR and of SVMC will re-educate M.D.s on the proper way of ordering pain medication. Nursing staff at CLR will be educated to not accept M.D. orders for pain medication without a range or an indication for use. If an order is written without a range or an indication</p>	

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F 329	Continued From page 7 the applicable sample (Resident #45) had a complete order for an as needed (PRN) narcotic. The findings include: Per medical record review of Resident #45 at 4:45 PM on 12/06/2011, an order for a narcotic, Oxycodone, does not include the parameters for the dose to be administered, nor the indication for use other than PRN (as needed). Per the physician's admission order dated 11/04/11, Resident #45 has a scheduled narcotic order for Oxycodone 5 milligrams every 4 hours while awake. An Emergency room physician's order dated 11/13/11 states 'Oxycodone 5 mg, 1- 2 tablets, q 4-6 hours PRN', which is presently on the Medication Administration record (MAR). In addition, review of the MAR shows on 11/22/11 the scheduled midnight Oxycodone as circled [the item as not being given] but then signed [as being given] with the additional PRN dose being given at that same time. Per interview on 12/07/11 at 10:30 AM the Unit manager stated the PRN medication "appears to be a duplication" and confirmed that there was no parameters nor indications for its use.	F 329	for use, the M.D. will be called or faxed for clarification. Pharmacy will also attempt to NOT process the order until clarified. Random audits will be conducted monthly and reported to Safety-Quality for 3 months. F329 POC accepted 1/5/12 Semmons R / Director 1/27/12
F 431 SS=B	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431	F431 -

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F 329 Continued From page 7
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F 431 483.60(b), (d), (e) DRUG RECORDS, SS=B LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be

F 329

~~Random audits will be conducted monthly and reported to Safety-Quality for 3 months.~~

See previous.

1/27/12

F 431

F431 -
The 3 vials of Tubersol were destroyed when found. There are no vials of open Tubersol in the building without a date. When the night nurse checks the refrigerator temperatures, s/he will check vials of Tubersol for a date if they are open. Policy and procedure will be followed if any vials found open without a date. Refrigerator

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F 431 Continued From page 8

labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on review of manufacturer recommendations, observation and interview, the facility failed to ensure that medications were dated when opened to ensure they were stored and used as recommended by the manufacturer. This affected 3 vials of Tubersol (a tuberculin purified protein derivative used to test for exposure to tuberculosis) located in two (Allen and Coolidge/Rockwell) of three medication storage rooms in the facility. Findings include:

1. During observation of the Allen hall medication

F 431 temperature logs with medication check will be reviewed monthly and reported to Safety-Quality Committee by the DNS for 3 months.

F431 POC accepted 11/5/12
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1/27/12

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

PRINTED: 12/21/2011
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 12/07/2011
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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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(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 431	<p>Continued From page 9</p> <p>storage room on 12/07/11 at 8:25 A.M. with the Allen unit charge nurse, one vial of Tubersol was observed to be opened and undated in the medication refrigerator. Review of the package insert revealed that the vial should be discarded after it has been entered and in use for 30 days because oxidation and degradation may have reduced the potency. The charge nurse verified the vial was opened and undated and stated during interview that there was no way of knowing how long the vial had been in use without identification of the open date.</p> <p>2. During observation of the Coolidge/Rockwell unit medication storage room on 12/07/11 at 10:15 A.M. with the unit Registered Nurse assessment coordinator, two vials of Tubersol were observed to be opened and undated in the medication refrigerator. Review of the package insert revealed that the vial should be discarded after it has been entered and in use for 30 days because oxidation and degradation may have reduced the potency. The assessment nurse verified the vial was opened and undated and stated during interview that there was no way of knowing how long the vial had been in use without identification of the open date.</p>	F 431		