STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. Building B. Wing	08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bennington Health & Rehab	2 Blackberry Lane Bennington, VT 05201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 40258 Based on observation, interview, and record review the facility failed to inform the resident's Power of Attorney (POA) of a change in condition related to the development of a pressure ulcer for 1 of 6 residents in the applicable sample (Resident #3). Findings include: Per record review Resident #3 has a history of a stage 1 pressure ulcer of the right outer ankle that was resolved on 6/10/2022. A skin check documented on 8/9/2022 states (R) [right] Ankle Deep Red 1.25 cm circular, no [not] open. A skin check documented on 8/12/2022 states (R) Ankle now stage 2 superficially open. RN will obtain Rx [prescription] order. A nurse's progress note written on 8/16/2022 at 14:39 states (R) [Right] ankle wound base today with visible screw appears to be working its way out as causative factor in rapid progression/reopening of previously healed PU [pressure ulcer]. FNP [family nurse practitioner] notified of same. Resident remains on Palliation/ comfort care with No antibiotics as part of [her/his] Advanced Directives. Tx [treatment] applied by staff nurse as ordered by FNP yesterday. There was no evidence in the medical record that the resident's POA was notified of the change in condition related to the developement of the right ankle wound. Per interview with a staff registered nurse (RN) on 8/19/2022 at 4:30 PM, when the dressing to the right ankle was removed on 8/16/2022 a large open wound with a piece of hardware [surgical screw] protruding from it was revealed. The FNP was notified of the wound however, as of 8/19/2022 the resident's POA had not been notified. Per phone interview with Resident # 3's POA on 8/26/2022 at 3:17 PM, a nurse from the facility had contacted her/him on either 8/23/2022 or 8/24/2022 to provide an update regarding an increase in the dose of Morphine being administered due to increased pain. This is when s/he first learned that the right ankle wound had reopened with an exposed surgical screw. The POA confirmed that s/he had not been notified of the wound when it had been identified on 8/9/2022, or as it progressed on 8/12/2022 and 8/16/2022 until the call 14 or 15 days after the initial discovery, regarding the increase dose of Morphine.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40258 Based on observations, interview, and record review the facility failed to ensure that two of six residents in the applicable sample (Residents #1 and #2) received adequate supervision to prevent accidents, injury, and/or potential abuse. Findings include: 1. Per record review Resident #1 has diagnoses that include major depressive disorder, and Alzheimer's Disease. S/he has a history of exhibiting verbal and sexual behaviors toward staff and other residents. A Social Service Note written on 5/8/2022 reflects a care plan focus of behavior problem due to acute delirium as evidenced by agitation, combativeness, wandering, yelling, refusing food, fluid, medications, **Calling all [women/men] [s/he] sees [significant other's name] and asking them to inappropriately touch [her/him]. On 7/22/2022 at approximately 7:30 PM another resident was found leaning over Resident #1 with their hands under a lap blanket. A statement written by a Licensed Practical Nurse who was on duty states [Her/His] hand appeared to be near [Resident #1's] groin region . [Resident #1] was yelling out as this contact was happening but in a more amplified way than any of [her/his] other behaviors that night. When the residents were separated, Resident #1 began to remove her/his brief and was noted to have been incontinent of bowel. The other resident was later found to have feces on her/his hand. On 7/25/2022, three days after the incident, a care plan intervention was added to Attempt to keep [resident] away from [Female/Male] Dementia Residents who don't know not to respond to [her/his] inappropriate invitations to touch [her/him]. An intervention added to the care plan on 7/26/2022 states Dr in and ordered increase in Seroquel due to unrelenting behaviors of screaming, crying for [SO] and [her/his] parents and calling out (often times calling to [female/male] residents to come to [her/him] with sexually explicit requests for them to do to [her/him]). and Medication Changes to decrease inappropriate sexual invitations. However, there were no interventions in the resident's care plan regarding the need for supervision related to aggressive behaviors or the risk for potential inappropriate touching or sexual abuse. During interview with a Registered Nurse (RN) on the 3 South Unit on 8/17/2022 at approximately 2:30 PM, s/he confirmed that there had not been a specific plan to ensure Resident #1 was safe from undesired sexual contact due to her/his known behaviors. The RN stated that staff try their best to supervise the residents, but it is impossible to supervise them all the time and do medication pass and help the LNAs when they need it. During phone interview on 8/11/2022 at 4:06 PM with the Director of Nursing (DNS) at the time of the incident, Resident #1 has a history of thinking others are her/his significant other and requesting that they touch her/him and do things to her/him that are sexual in nature. S/he stated that s/he believed that Resident #1 asked the other resident to touch her/him, and the other resident did. The previous DNS confirmed that the resident had a long history of behaviors however, there had been no specific plan in place to prevent negative outcomes resulting from them. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. Per record review Resident #2 has diagnoses that include repeated falls, unsteadiness on feet, difficulty walking, anxiety, dementia, psychosis, cognitive communication deficit, and tremor. Review of nurse progress notes revealed that the resident has had 41 documented falls between 1/1/2022 - 8/17/2022. 35 of the documented falls were unwitnessed with the 6 others documented as witnessed by staff. Per progress notes the resident suffered minor injuries from falls on 1/1, 3/7, 3/8, 5/1, 6/9 (head injury with visit to emergency room for scan), 6/20, and 8/17. A care plan focus initiated on 2/7/2021 states [Resident] has a potential for falls related to: Agitation, Cognitive Impairment, and HTN (hypertension). Care plan interventions implemented on 2/24/2022 that state Staff should intervene and accompany [resident] as soon as they note [her/him] attempting to walk unassisted were changed on 4/5/2022 to Line of Sight supervision and not allowed to enter rooms unaccompanied because [s/he] is unsafe in [her/his] judgement as to where and when to sit. The Activities of daily living care plan does not address the resident's ambulation status or level of assistance needed for ambulation. During unit observations on 8/11/2022 at 11:00 AM, Resident #2 was observed on the floor in her/his room. The Licensed Practical Nurse (LPN) on duty confirmed that the resident had just had an unwitnessed fall and they were getting her/him up off the floor. Per review of progress notes from 8/11/2022 there was no documentation that the resident had a fall or that s/he had been assessed for injury. On 8/17/2022 Resident #2 sustained two unwitnessed falls and was sent to the emergency room for evaluation. On 8/17/2022 at 2:30 PM during interview a Licensed Nurse Assistant (LNA) who works on 3 North stated that Resident #2 needs 1:1 supervision to prevent falls, but the facility does not provide that kind of care. S/he stated that even though it's kind of the dementia unit we don't have the ability to provide true dementia care. Per interview with a LNA on 8/17/2022 at approximately 4:30 PM Resident #2 has multiple unwitnessed falls especially on the evening shift. There is not enough staff to provide the kind of supervision or assistance that s/he needs. On 8/19/2022 at 11:27 AM during a phone interview with a Registered Nurse (RN) who is frequently assigned to Resident #2 s/he stated we don't have the staff to take care of [her/him] [s/he] should be 1-1 but never is. We just don't have the staff to do the basics. The RN also stated The resident was sent out the day before. S/he has a UTI [urinary tract infection] and dozens of undocumented and unreported falls, especially on evening shift. When asked if there is any specific expectation for supervision, the RN stated S/he is care planned to fall, low bed with mats to prevent injury from fall. The RN confirmed that the resident is care planned for line of site supervision for safety however, most of the falls sustained by the resident are unwitnessed.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 40258 Based on observations, interviews, and record review the facility failed to ensure sufficient staff to provide nursing and related services to assure all resident care and safety needs were met. 1. During observations of the 2nd floor on 8/11/2022 at 12:45 PM the Registered Nurse (RN) on duty reported that each day there is one RN or Licensed Practical Nurse (LPN) and one Licensed Nurse Assistant (LNA) assigned to the unit each shift. According to the RN s/he is responsible to assist the LNA with resident care needs and transfers with mechanical lifts which require 2 staff assistance in addition to nursing duties such as medication pass and treatments. The RN stated, there is going to be three new admissions today and one is on Hospice. The RN also stated that when s/he or the LNA go to lunch it only leaves one person on the floor. Per interview on 8/11/2022 at 2:15 PM with the LNA assigned to the 2nd floor there are now 15 residents who reside on the unit. Two new admissions arrived today, and a Hospice patient is also being admitted today. The LNA stated I am told that the residents on this unit don't need a lot of help. Even the residents who don't need help with their care still have needs. Per the LNA there are 4 residents on the unit that require the use of a 2 person Hoyer lift at least twice during the shift and s/he has to ask the nurse to help her/him each time. This takes the nurse away from their duties like medication pass and treatments. I have residents who need to be turned, and changed, a lot of them don't like to undress at night so I have to undress them, clean them, and dress them back up. It's just too much for one person. When we take our lunches, it only leaves one person on the whole floor, and it's not safe. When asked if there are care needs that don't get met, the LNA stated sometimes. Review of the facility Daily Attendance Report for July and August 2022 confirmed that the 2nd floor is consistently staffed with one RN or LPN and one LNA on all three shifts. Per interview with the Director of Nursing (DNS) on 8/11/2022 at 6:15 PM the residents on the 2nd floor do not require a lot of care. The facility has not been admitting residents to the 2nd floor South Unit because of staffing. However, the new Hospice admission was being admitting to the South Unit. The DNS confirmed that there is only one nurse and one aide scheduled on the 2nd floor. 2. On 8/11/2022 at 4:45 PM per interview with a contract Licensed Practical Nurse scheduled on the 3rd floor South Unit on there are two LNAs and her/himself scheduled on the unit which is per normal. S/he stated that there is not enough staff to do everything and keep the residents safe. There are so many behaviors on the evening shift and there is nobody here to help. Per review of the Resident Census and Conditions of Residents report dated 8/11/2022 there are 25 residents with documented psychiatric diagnosis (excluding dementia and depression), 19 residents with dementia or Alzheimer's Disease, 8 residents with behavior healthcare needs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During observations throughout the on-site investigation the Activities Calendar was noted on the unit. Per review the last activity provided on each day throughout the month is at 3:30- 4:00 PM. Per interview with the facility Executive Director on 8/17/2022 at there is an open position for evening activities that has not been filled. She confirmed that there were currently no activities offered after 4:00PM. 4. Per record review Resident #2 has diagnoses that include repeated falls, unsteadiness on feet, difficulty walking, anxiety, dementia, psychosis, cognitive communication deficit, and tremor. Review of nurse progress notes revealed that the resident has had 41 documented falls between 1/1/2022 - 8/17/2022. 35 of the documented falls were unwitnessed with the 6 others as witnessed by staff. A falls care plan intervention reflects that the resident should be in Line of site supervision. Per interview with several staff members there is not enough staff to provide adequate supervision to this resident. It is not possible for them to supervise the resident all the time, especially on evening shift when there are only four LNAs and two nurses between 3rd floor North and South Units. Per interview with a LNA on 8/17/2022 at approximately 4:30 PM there is not enough staff to provide the kind of supervision or assistance that s/he needs. Resident #2 has multiple unwitnessed falls especially on the evening shifts. Refer also to F689.