

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475027	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/02/2024
NAME OF PROVIDER OR SUPPLIER  Bennington Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>40258</p> <p>Based on interview and record review the facility failed to ensure that a resident's right to be treated with dignity and respect was maintained for 1 of 3 residents in the sample (Resident #1). Findings include:</p> <p>During an interview on 5/1/24 at approximately 12:35 PM Resident #1 stated, I have lost my rights as a person, and I feel like I am being targeted . The previous Director of Nursing (DON) hung letters about me at the nurse's station and had things in my care plan that were not true. The resident was visibly upset about the content of the letters, stating s/he felt humiliated that this note was hung for everyone to see. Resident #1 also said that months ago a Nurse who is now the Interim DON had called the police on her/him because s/he got angry when the Nurse would not let her/him go outside alone.</p> <p>Per review of the letter that Resident #1 said had been hung up at the nurses station, it specified three Licensed Nursing Assistants (LNAs) by name who should not provide personal care, and one LNA who should not go in Resident #1's room for any reason unless a true emergency. The note says that Resident #1 is independent in personal care once provided with a basin of water and fresh towels, s/he does not require an LNA to wash, or apply creams to her/his genitals. It further states that Resident #1 [name written] has completed her/his rehab plan of care and is independent and should not be allowed to pull the young girls/boys into her/his room insisting that they wash her/his genitals, stating that this is a behavior, not a personal care need. Finally, the note states that s/he also does not require an hour long shower; 20 minutes for a shower is more than adequate and should not be provided by the young LNAs whom s/he is targeting.</p> <p>Per interview on 5/2/24 at approximately 1:30 PM with an Licensed Practical nurse (LPN) who was familiar with the care needs of Resident #1, the Resident is not hard to get along with if you just listen to her/his concerns. The LPN confirmed that the note that discussed Resident #1's personal information had been posted at the nurse's station, and pointed to an area that was visibly accessible to anyone standing at the station, including other residents and visitors. The LPN also stated s/he understands why the Resident would be upset about a note like that being posted.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Per record review, there were two occasions on 10/5/23 where it appears that the treatment by staff triggered emotions and subsequently behaviors, when other approaches could have prevented escalation. These resulted in police being contacted for the angered response of the resident when staff did not allow them to exercise their right to go outside and when staff refused to administer requested pain medication and inappropriately outlined the work that would need to be done by nursing to give them their scheduled pain medication.</p> <p>Per record review a nursing progress note written on 10/5/2023 states This writer arrived at BHR for work at [6:45 PM] when [ I ] saw [Resident #1] wheeling [themselves] into the lobby. This writer approached the resident and asked [her/him] where [s/he] was going. The resident responded that [s/he] was leaving and going outside to be alone and not to follow [them]. The nurse documented that after s/he provided education to Resident #1 about concerns for their safety and why s/he could not be left alone unsupervised outside. Resident #1 became verbally irate towards staff. After speaking with a different staff member for a period of time the staff member was asked to leave as their shift had ended. At this time the resident became verbally aggressive again. The note states This resident was given many chances to return to the floor with multiple different staff members, all of which [s/he] refused. At this time, this writer contacted the DON and was advised to call the local police and EMS (Emergency Medical Assistance). The resident continued to refuse the option to return to the floor and refused to be transported to the ER. At this time EMS and local police left the scene and this writer sat one on one with the resident in the lobby.</p> <p>A nursing progress note written on 10/5/2023 states At [9:15 PM] the resident wheeled [her/himself] into the elevator and returned back to the 3rd floor. At approximately 9:35 PM the Resident demanded their pain medication and the nurse said that the Resident could no longer receive her/his scheduled 8:00 PM dose because it was outside the one hour window and that the doctor would have to be contacted to have the time changed. The note states that the resident began verbally assaulting the staff and demanded the Nurse give [her/his] pain medication now. Resident #1 escalated and the Nurse called the local police at [9:39 PM]. The Nurse was advised by the Administrator to have the resident removed from the facility as [s/he] was continuing to verbally and physically assault staff. When the police arrived at the facility the resident refused to leave. At this time a decision was made by the administrator, police officer and staff that [Resident #1] could remain here but if [s/he] were to become escalated with staff again the police would come remove [her/him] from the facility immediately.</p> <p>During an interview on 5/2/24 at 1:35 PM the DON confirmed that Resident #1 became aggressive on 10/5/23 when the Nurse had told her/him that s/he could not go outside alone and s/he had called the police. Staff had been instructed to do so if Resident #1 became aggressive.</p>		