STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475029	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center for Living & Rehabilitation	160 Hospital Drive 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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44192 Based on resident interview, staff interview, and record review, the facility failed to ensure that all residents were treated with respect and dignity by all staff for one of 29 sampled residents (resident #87). Findings include: Per interview on 3/19/24 at approximately 2:00 PM, Resident #87 stated that about a month ago a staff member swore at them during an interaction. They stated that the interaction upset them at the time, but that they worked it out and there is no ongoing concern with the Licensed Nursing Assistant (LNA). Per record review, Resident #87 has a care plan for [Resident #87] can be verbally aggressive, yelling at staff, swearing at staff, and gestures aggressive towards staff r/t Poor impulse control initiated on 5/6/23. Per an MDS assessment on 1/10/24, Resident #87 has a Brief Mental Status Score of 15 (high congnitive function). Per review of the incident documentation from the facility, the LNA confirmed that they swore at the resident during an interaction in which Resident #87 was swearing at the LNA for the way that the LNA was emptying Resident #87's urinal. The LNA swore at Resident #87 under their breath as they left the room. Per Administrator interview with Resident #87 on 3/20/24, they did not want to stop working with the LNA, as they normally have a very positive relationship, and that they just wanted to have a facilitated conversation with the LNA to [NAME] the [NAME]. This was arranged by the facility to the satisfaction of Resident #87. Per interview on 3/19/24 at approximately 3:00 PM, the Administrator confirmed that the allegation of undignified treatment by the LNA towards Resident #87 was substantiated.

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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 46135 Based on interview, record review, and policy review, the facility failed to implement policies for screening employees by not completing the required criminal background checks for 4 out of 5 sampled staff. Findings include: Facility policy titled Background Checks, Arrests, and Conviction Notification, last revised on 3/4/2024, indicates that the facility will conduct criminal background checks for all current employees at least annually. Per review of employee human resource files, 4 of 5 sampled direct care staff who have worked at the facility for over a year do not have annual federal background checks completed. Per interview on 3/20/24 at 11:45 AM, the Human Resource Staff explained that there is no system in place for obtaining annual national background checks for staff that have been here over a year but has worked with the Administrator to implement completing annual background checks in starting in June.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 29776 Based upon interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, are reported not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) for 1 resident [Res.#101] of 2 sampled residents regarding abuse allegations. Findings include: Per review of the facility's Investigation Summary of an incident involving Res.#101 on 2/17/24, the Witness Statement by a Licensed Practical Nurse (LPN) present reveals on 2/17/24, a staff member was witnessed accusing Res.#101 of tampering with their ostomy appliance, causing the resident's eyes to tear up. The resident stated they didn't touch it but the staff member continued as if it were [Res.#101's] fault. The witness statement continues As [Res.#101] lay naked on the bed with poop all over [her/him], [Staff member] berated [her/him]: again, tears welled up in [Res.#101's] eyes. After the staff member left the room, Res.#101 told the LPN That [wo/man] has been accusing me all week and stated it makes me feel like crap. The LPN's witness statement is dated 2/17/24 at 11:25 PM. A review of the LPN's Supervisor's statement, dated 2/20/24 [3 days after the incident], records the LPN spoke with the supervisor shortly after the supervisor arrived for the 11:00 PM shift on 2/17/24. The Supervisor reported the LPN stated 'there could have been some verbal abuse that happened', and Supervisor asked the LPN to write down a statement of what happened. [LPN statement dated 2/17/24 at 11:25 PM]. The Supervisor then went to the Unit Manager [UM] to follow up, and the UM informed the Supervisor that [s/he] had investigated the situation and reported zero findings. Review of the Unit Manager's statement, also dated 2/20/24, 3 days after the incident, records that on 2/17/24 the UM was summoned to Res.#101's room where the LPN was saying something was inappropriate, with the UM writing I am unsure of what this was, as I was not in the room. The UM continues that after shift change the LPN reported Res.#101 requested to speak to the UM. The UM recorded that Res. #101 was emotional when I went to see [her/him], and prefaced I did not hear what was said regarding the abuse allegation. The UM's statement does not report any further investigation into the abuse accusation, including speaking with the accused staff member, speaking with the LPN or another staff member present in the room, or reading the LPN's witness statement. The UM's statement does include acknowledgment that the accused staff member was allowed to continue working with Res. #101 all night. Review of the facility's Investigation Summary reveals On Monday 02/19/2024 at 4 p.m. it was brought to the attention of the Administrator and the Director of Nursing that [the LPN] felt that [the staff member] was verbally inappropriate when providing care to [Res.#101's] Ileostomy on Saturday 02/17/2024. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing on 3/19/24 at 2:19 PM. The DON confirmed that the allegation of Verbal Abuse of Res.#101 which occurred on 2/17/24 was not reported to the mandated agencies within 24 hours, as required by state and federal regulations. The DON also confirmed that per regulation and per the facility's policy, after the LPN reported the abuse allegations to the Supervisor, the Supervisor and the Unit Manger failed to 'report to the Administrator and/or Director of Nursing Services or designee, who reports to the Division of Licensing and Protection.'

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 29776 Based upon interview and record review, the facility failed to assure that further potential abuse, neglect, exploitation, or mistreatment did not occur after an allegation of abuse for 1 resident [Res.#101] of 2 sampled residents regarding abuse allegations. Findings include: Per review of the facility's Investigation Summary of an incident involving Res.#101 on 2/17/24, the Witness Statement by an LPN present reveals on 2/17/24, a staff member was witnessed accusing Res.#101 of tampering with their ostomy appliance, causing the resident's eyes to tear up. The resident stated they didn't touch it but the staff member continued as if it were [Res.#101's] fault. The witness statement continues As [Res.#101] lay naked on the bed with poop all over [her/him], [Staff member] berated [her/him]: again, tears welled up in [Res.#101's] eyes. After the staff member left the room, Res.#101 told the LPN That [wo/man] has been accusing me all week and stated it makes me feel like crap. The LPN's witness statement is dated 2/17/24 at 11:25 PM. A review of the LPN's Supervisor's statement, dated 2/20/24 [3 days after the incident], records the LPN spoke with the supervisor shortly after the supervisor arrived for the 11:00 PM shift on 2/17/24. The Supervisor reported the LPN stated, 'there could have been some verbal abuse that happened', and Supervisor asked the LPN to write down a statement of what happened. [LPN statement dated 2/17/24 at 11:25 PM]. The Supervisor then went to the Unit Manager [UM] to follow up, and the UM informed the Supervisor that [s/he] had investigated the situation and reported zero findings. Review of the Unit Manager's statement, also dated 2/20/24, 3 days after the incident, records that on 2/17/24 the UM was summoned to Res.#101's room where the LPN was saying something was inappropriate, with the UM writing I am unsure of what this was, as I was not in the room. The UM continues that after shift change the LPN reported Res.#101 requested to speak to the UM. The UM recorded that Res. #101 was emotional when I went to see [her/him], and prefaced I did not hear what was said regarding the abuse allegation. The UM's statement does not report any further investigation into the abuse accusation, including speaking with the accused staff member, speaking with the LPN or another staff member present in the room, or reading the LPN's witness statement. The UM's statement does include acknowledgment that the accused staff member was allowed to continue working with Res.#101 all night. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing on 3/19/24 at 2:19 PM. The DON confirmed that despite abuse allegation regulations and per the facility's Abuse, Neglect and Exploitation policy [modified on 3/4/24] , the facility failed to prevent further potential abuse, neglect, exploitation, or mistreatment when the Supervisor and UM failed to remove the alleged perpetrator, providing safety to the resident after the allegation of Verbal Abuse of Res.#101 which occurred on 2/17/24. The DON confirmed that Resident Task records document that the accused staff member continued to work with the resident after the incident on 2/17/24 into the morning of 2/18/24, which was also confirmed in the UM's statement on 2/20/24. Further review of the facility's Investigation Summary reveals On Monday 02/19/2024 at 4 p.m. it was brought to the attention of the Administrator and the Director of Nursing that [the LPN] felt that [the staff member] was verbally inappropriate when providing care to [Res.#101's] Ileostomy on Saturday 02/17/2024. The DON confirmed that a full investigation into the abuse allegation on 2/17/24 was not initiated until 2/19/24.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 44192 Based on staff interview and record review, the facility failed to ensure that each resident's medical record contains documentation that indicates that the resident or resident's representative was provided education regarding the benefits and potential side effects of the COVID-19 immunization before receiving the vaccine for 1 of 5 sampled residents (Residents #100). The facility also failed to ensure that each eligible resident receives the COVID-19 vaccine for 1 of 5 sampled residents (Resident #6). Findings include: 1. Per record review, resident #100 received the Fall 2023 COVID-19 immunization on 3/20/2024. There is no evidence in the record that Resident #100 or their representative was provided education regarding the benefits or side effects of the immunization. Per interview on 3/20/24 at approximately 4:30 PM, the facility's Infection Preventionist confirmed that no documentation could be located in the record to validate that Resident #100 was provided education regarding the benefits or side effects of the immunization prior to vaccination. 2. Per record review, resident #6 was not provided the Fall 2023 COVID-19 immunization. There is no evidence in the record that Resident #6 or their representative was provided education regarding the benefits or side effects of the immunization or that the Resident or representative had signed consent to receive or not receive the immunization. Per interview on 3/20/24 at approximately 4:30 PM, the facility's Infection Preventionist confirmed that there was no signed consent to either give the COVID-19 immunization to Resident #6, or that Resident #6 or their representative had refused the immunization. They stated this was because Resident #6 was currently in the process of obtaining a Power of Attorney (POA) and that they needed that sorted out before obtaining consent because Resident #6 does not have the capacity to consent. Per further record review, Resident #6 signed consent for the Fall 2023 influenza vaccine on 10/31/23 themselves and received the vaccine the same day. Per review of communications between the facility and their immunization provider, the facility received COVID-19 vaccinations on 11/2/2023, two days after Resident #6 signed consent to receive the Fall 2023 influenza vaccine. Per interview on 3/20/24 at approximately 5:00 PM, the Infection Preventionist confirmed that Resident #6 could have signed consent for the Fall 2023 COVID-19 immunization at the same time as the influenza immunization and received the COVID-19 immunization when the facility received the vaccines.