

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

May 3, 2012

Ms. Melissa Jackson, Administrator  
Vermont Veterans Home  
325 North Street  
Bennington, VT 05201-5014

Provider #: 475032

Dear Ms. Jackson:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **April 4, 2012**. 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

RECEIVED  
Division of  
APR 23 12

PRINTED: 04/13/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475032</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/04/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VERMONT VETERANS HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>325 NORTH STREET BENNINGTON, VT 05201</b>
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F 000	INITIAL COMMENTS  An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 04/04/12. There were regulatory violations.	F 000	Please note that the filing of this plan of correction does not constitute any admission as to any of the alleged violations set forth in this Statement of Deficiency. The POC is being filed as evidence of the Facility's continued compliance with all applicable laws.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide services in accordance with the written plan of care for 1 applicable resident (Resident #2). The findings include:  1. Per record review on 04/04/12 of Resident #2's chart, the resident has a diagnosis of dementia with agitation and is care planned with interventions to divert confrontations. The care plan for behavior and mood directs staff to provide 1:1 time, offer coffee and sweets, encourage participation in activities such as cowboy movies and a too:box. The LNA (licensed nursing assistant) care plan also states to watch for increasing behaviors towards evening and to monitor aggression. Per interview on 04/04/12 at 11:15 AM the unit nurse stated that just prior to an incident between Resident #2 and Resident #1 on 04/02/12, staff had to re-direct Resident #2 out of Resident #1's bedroom. That re-direction consisted of walking the resident out into the hallway. Per interview at	F 282	<b>F282</b> <u>Corrective Action:</u> LNA assignment sheet updated with specific interventions to attempt. Complete Behavioral IDT Plan has been developed and made available to staff on the floor for Veteran #2.  <u>Other Residents:</u> All Residents with wandering behaviors are at risk.  <u>Systemic Changes:</u> Behavior profile/interventions for each Veteran with behavior are being developed. Includes approaches that have been effective for the Veteran and what to do when not able to redirect or is a safety risk to self or others. Staff is being re-educated in an interactive setting whole house on the behavior profiles and interventions.  <u>Monitoring:</u> IDT will review 100% of Behavioral Incident reports to assure a behavioral plan is in place and interventions are complete and appropriate. Audits to continue for 90 days and audit results will be reviewed at bimonthly QA meeting.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Melissa A Jackson BSW, LNA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/19/12</i>
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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 282	Continued From page 1 2:00 PM, the LNA stated that on the afternoon of 04/02/12 s/he was checking residents' alarms, was aware that Resident #2 was re-directed out to the hallway, and confirmed Resident #2 was not offered activities or other interventions as care planned at that time. Per interview at 4:00 PM the Assistant Administrator confirmed that staff did not offer or provide services according to the written care plan.	F 282	<u>Compliance Date:</u> April 26, 2012  <i>F282 POC accepted 5/2/12 SEMMONS/RN/ Pincoturn</i>	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  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.  This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to ensure that fall devices and interventions were consistently implemented to prevent an accident for 1 applicable resident. (Resident #1). The findings include:  1. Per record review, on 04/04/12, Resident #1, who has a diagnosis of advanced dementia, syncope episodes, general weakness, and chronic anemia, sustained a fall resulting in injury on 04/02/12. Per the care plan dated 11/14/11 for rehabilitation and ADL (Activities of Daily Living)/falls, it directs staff to provide close supervision, rolling walker, rise alarm on bed at all times, every 15 minute checks, non-skid	F 323		

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F 323	<p>Continued From page 2</p> <p>footwear, and bed in lowest position. Per review of the nursing notes of 03/25/12, 03/26/12, 03/27/12 and 04/02/12, staff noted that the resident had very unsteady gait, was wobbly and made multiple attempts to get out of bed on his/her own, in which there was a fall, helped to the mat, and assisted to a chair, respectively.</p> <p>Per the Quality Assurance Incident Investigation and the SBAR sheet [situation, background, assessment, request] dated 04/02/12 at 5:00 PM, Resident #1 was found unresponsive on the floor at approximately 3:00 PM near the foot of the bed. It was noted that the alarm was "unplugged" at the time of this fall. The resident sustained fractures of the face. Per interview on 04/04/12 at 10:45 AM, the DNS stated that the process for checking the bed alarm is that at the end of each shift 2 LNAs [out going and in coming staff] will make rounds together, move the resident out of the bed [preferably] to see if the alarm is working correctly and then sign off on the check list sheet. Per interview at 2:00 PM, the LNA who was monitoring the alarms on the afternoon shift on 04/02/12 stated that s/he was the only one checking alarms that afternoon and that the day shift staff 'must have signed off during the day'. In addition, the LNA stated that on 4/2/12 Resident #1 was in the bed, facing the window and although the resident was awake and resting quietly, the LNA didn't want to disturb the resident, so the LNA unplugged the alarm, it beeped and the LNA then plugged it back in. The LNA confirmed that the correct way is to move the resident and off-weight the alarm to see if it works, which was not done. Per interview at 4:30 PM the DNS confirmed that that fall devices and interventions were not consistently implemented</p>	F 323	<p><b>F323</b></p> <p><u>Corrective Action:</u> Unit staff in-serviced on alarm check procedure and LNA change of shift procedure. Accountability form updated and implemented immediately.</p> <p><u>Other residents:</u> All Residents with alarms are at risk.</p> <p><u>Systemic Changes:</u> All Nursing Staff will be educated for procedure for checking alarms. All Nursing staff will demonstrate competence in setting up and checking alarms.</p> <p><u>Monitoring:</u> Education will track that all staff have a competency yearly. Weekly random audits of all alarms on each unit for proper functioning as well as monthly spot check observations by DNS or designee that staff are following alarm and change of shift procedures.</p> <p>Audits to continue for 90 days and audit results will be reviewed at bimonthly QA Meeting</p> <p><u>Compliance Date:</u> April 26, 2012</p> <p><i>F323 POC accepted 5/2/12 SEMMONSRN/PRMctARN</i></p>	

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F 323	Continued From page 3 to prevent an accident.	F 323		
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