



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
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August 31, 2009

Colleen Rundell, Administrator
Vermont Veterans Home
325 North Street
Bennington, VT 05201

Provider #: 475032

Dear Ms. Rundell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 23, 2009**. Please post this document in a prominent place in your facility.

We will 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,

Suzanne Leavitt, RN, MS
Licensing Chief

Enclosure



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

PRINTED: 08/07/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2009
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NAME OF PROVIDER OR SUPPLIER VERMONT VETERANS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 325 NORTH STREET BENNINGTON, VT 05201
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F 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 6/2/09 and completed on 7/23/09. The following deficiency was cited.	F 000	F 241 At this time, the Vermont Veterans Home will note the following. There are flagrant misrepresentations within this statement of deficiencies. These will now be detailed.	
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident was treated with consideration and respect when the resident was given a 30 day notice of their pending involuntary discharge from the facility. (Resident #1) Findings include: Without arranging for emotional support of family or staff, the Administrator directed the Director of Social Services to present notification of an involuntary discharge to Resident #1, an individual at the end stage of a terminal illness and who was also diagnosed with depression. On 10/10/08, a letter of 30 day notice for involuntary discharge for nonpayment of charges for a 6 month period was delivered by the Director of Social Services (DSS) to Resident #1. Per review on 6/2/09, the Minimum Data Set Assessment (MDS) completed on 10/9/08, section for "Stability and Condition", coded Resident #1 as follows: "condition/disease make resident's cognition, ADL, mood or behavior patterns unstable (fluctuating, precarious or deteriorating)". In addition, the assessment	F 241	Surveyor alleges that at the time that Rt. #1 was provided a 30 discharge notice, no emotional support was offered. Specifically, the surveyor states "without arranging for emotional support of family and staff..." This is an untruth. In fact, during the surveyor's interview with the DSS, who is an MSW and has 13 years of psychiatric (including in-patient) and geriatric experience, the clinician attempted to offer support but the resident requested she leave the room. Additionally, the DSS had notified the North Wing's Clinical Care Coordinator (CCC) and two facility social workers. The surveyor was also informed that additional staff was purposely not included in the notification so that the DSS would be the focus of the resident's anger. This would allow the resident the opportunity to be offered support by staff he knew were not involved in the intricacies of his financial issue. In fact, per the surveyor's own written narrative " Per interview on 6/02/09 at 1:00 pm the North Wing unit Clinical Care Coordinator confirmed that although he/she was made aware earlier in the day of the pending discharge notice, he/she was unavailable for the resident when the notice was delivered by the Director of Social Services. Upon visiting the resident shortly after the notice was given, the Clinical Care Coordinator confirmed Rt. was "...upset". The Surveyor acknowledges that support was provided by the CCC "shortly after the notice". Additionally, the rt. was provided support on 10/11/08, when the rt. was assessed and offered support by a social worker (see attached documentation of SW visit 10/11/08). The documentation reflects that resident had been prescribed fluoxetine (paxil) for depression on 10/9/09, one day prior to the discharge notice evidencing a previous existence of depression. In fact, resident was admitted with a long standing diagnosis of depression. On 10/12/08 resident was seen by a SW for emotional support (see SW note 10/12/08) and 10/15/08 his "usual SW" assessed resident and offered additional emotional support	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Catherine Rundell, M.S., LNHA TITLE Administrator (X6) DATE 8/19/09

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 241	Continued From page 1 coded: "resident experiencing an acute episode or a flare-up of recurrent or chronic problem". Per interview on 6/2/09 at 11:15 AM, the DSS confirmed that sometime during the day on 10/10/08, without supportive presence for the resident from nursing staff, the resident's family and/or other social service staff assigned to the resident, the DSS notified Resident #1 of the pending involuntary discharge. The DSS stated "He/she was upset and kicked me out of the room". Per interview on 6/2/09 at 1:00 PM the North Wing unit Clinical Care Coordinator confirmed, although he/she was made aware earlier in the day of the pending discharge notice, he/she was unavailable for the resident when the notice was delivered by the Director of Social Services. Upon visiting the resident shortly after the notice was given, the Clinical Care Coordinator confirmed Resident #1 was "...upset". Per review, a social services progress note for 10/11/08 stated "Asked to see resident. He/she was upset and depressed over medicaid and he/she said got a notice of discharge from the home yesterday". During interview on 6/2/09 at 1:30 PM, the Administrator confirmed that although Resident #1 was not handling their bills since becoming ill, the facility was required to issue the discharge notice to the resident and preferred not to "...involve the team with financial issues".	F 241	"resident appears less depressed" "1:1 support will continue." (See 10/15/09 SW note). Resident was seen regularly after the provision of the discharge notice for support and by more than one social worker. The facility will also note that the Rt. and his wife were aware and upset regarding the Medicaid application as early as 5/3/08. Non-payment was not a new issue. See SW note. The VVH will now address the following Surveyor written statement "Per review of 6/02/09, the MDS assessment completed on 10/09/08. This statement is erroneous. The MDS R2B4 Rap completion date was 10/14/08. However, the assessment reference date includes look back periods of 7 or 30 days. Hence, the look back period for the 10/09/08 MDS was 9/27/08-10/3/08 for the 7-day look back and 9/4/08 - 10/3/08 for the 30-day look back. Rt. #1 was re-admitted from the hospital on 9/25/08 after a two day ICU visit for an MI, acute urinary retention, urosepsis, and a new stage II pressure ulcer. He was readmitted with an acute medical condition and new disease diagnosis (see diagnosis sheet). Therefore, in the 7-day look back period MDS coding item J 5 coded A (conditions/diseases make resident's cognitive, adl, mood, or behavior pattern unstable or fluctuation, precarious or deteriorating). Rt #1 was coded for this prior to the 30 day notice due to his new medical diagnosis, new conditions and his choice to sign out AMA. B (resident experiencing an acute episode or flare up of recurrent or chronic problem). He was coded due to his acute condition that caused his hospitalization. The surveyor's inclusion of sections J A and B as justification of his mood instability is erroneous. These areas were coded due to physical medical issues. On 11/21/08, physician note states "he requests care at VVH only. He is aware of likely imminent death due to ALS and feels better cared for at VVH. How much damage to his dignity occurred if he wanted to "only" remain at VVH? (See physician note 11/21/08).

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Let us be honest. No human being is going to be happy to receive an involuntary discharge notice. The surveyor during her investigation expressed to the administrator and the DSS that she felt it was inappropriate to give a dying man a discharge notice. The MDS on 10/03/08 indicated that JC is not coded. JC asks "end stage disease, 6 or fewer months to live. The resident did have a terminal disease however death was not imminent. Even when the administrator explained that the veteran was independent in decision making, alert, oriented x 3 spheres, memory intact, the surveyor continued to refute the necessity to provide the notice directly to the veteran. We believe bias and personal opinion are apparent through out this statement of deficiency

Further, the administrator did not state to the surveyor "Rt. #1 was not handling his bills". This administrator stated that although the rt. was not able to write his own checks, he was making all the familial financial decisions and he had instructed his wife to not pay the bill as he believed that the Department of Veterans Affairs should pay. Additionally, this administrator did not state a preference to not "involve the team with financial issues". This writer stated for a resident's dignity and privacy, that VVH does not involve the clinical care team. For example, financial information is not maintained in the medical record, but in a financial file maintained by the business office. In this case the CCC and other SW staff were notified so that the rt. could be offered support. These statements attributed to this administrator are incorrect and need to be removed form this statement of deficiencies.

Hence,

THE VERMONT VETERANS HOME
REQUESTS IDR

Assuming for the moment that the finding and determination of deficiency are accurate without admitting or denying that they are, our proposal for corrective action is as follows:

Rt. #1 expired on November 28, 2008. No intervention is possible.

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All residents who choose to voluntarily withhold payment for care received at the VVH have the potential to be impacted by this alleged practice.

The following corrective actions will be taken. The DSS will inform the resident that a financial issue exists and will request consent that family be included in the discussion. Family involvement will hinge upon consent of the resident.

The following systemic changes have been made to ensure the effectiveness of the stated corrective actions: The involuntary discharge notice policy was reviewed and revised to include this new language. The DSS was in-serviced on this change.

These corrective actions will be monitored in the following manners: Any rt. who receives involuntary discharge notices will have their SW documentation reviewed by the Assistant Administrator to ensure compliance with this plan of correction. Identified non-compliance will be immediately reported to the Administrator. Additionally, results of the audits will be reviewed by the Assistant Administrator and the DSS. The results of the aforementioned audits will be trended and reported to the Quality Assurance Committee. The Quality Assurance Committee will recommend further action if indicated to include re-education, disciplinary action, etc...

The Assistant Administrator will be responsible for this plan of correction.

8/28/09
P.O.C. Accepted
D. DeCintosh, RN
See Attached

8/12/09
8/12/09