



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
Fax (802) 241-2358

September 13, 2010

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

Dear Ms. Rundell:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on August 11, 2010. 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,

A handwritten signature in cursive script that reads "Pamela M. Cota".

Pamela M. Cota, RN
Licensing Chief



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

PRINTED 08/19/2010
FORM APPROVED
OMB NO. 0938-0394

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 08/11/2010
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NAME OF PROVIDER OR SUPPLIER VERMONT VETERANS HOME	STREET ADDRESS, CITY, STATE ZIP CODE 325 NORTH STREET RENNINGTON, VT 05201
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(X4) ID PREFIX TAG F 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 F 279 SS=D	<p>INITIAL COMMENTS</p> <p>An unannounced on-site complaint investigation was conducted on 8/11/10 by the Division of Licensing and Protection</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop a comprehensive care plan that describes the services to be furnished in order to attain or maintain the resident's highest practicable physical, mental and psychosocial well being for 1 applicable resident (Resident #1) Findings include</p>	F 000 F 279	<p>F 279</p> <p>The Vermont Veterans' Home will note the following before responding to this statement of deficiency. The Home had self-identified and self-reported this issue to the Department of Licensing and Protection</p> <p>Asstoring 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:</p> <p>Veteran/Member #1 expired prior to the 5/11/2010 investigation by Licensing and Protection. The Veteran's death was not as a result of these alleged deficiencies and the facility is unable to interview now on his/her behalf.</p> <p>Veterans/Members on American Way with new diagnoses since admission have the potential to be affected by this alleged deficien practice.</p> <p>The following measures were implemented to ensure that the identified practice does not recur. The comprehensive care planning policy and procedure was reviewed and revised on 25 August 2010. All Veterans' (Members') medical records on American Way were reviewed to identify new diagnoses and changes of condition in the past 90 days, care plan meetings were held and care plans were reviewed to ensure their capture (completed 30 August 2010). Nursing service staff was educated on the revised policy and expectations by the clinical care coordinator. A memo from the Director of Nursing to all clinical care coordinators was written with a review of F 279 and the administrative expectation that this regulation be met. Additionally, the clinical care coordinator responsible for this unit received supervisory education.</p> <p>These corrective actions will be monitored in the following manner: American Way will be audited 5 times weekly for 90 days to ensure the effectiveness of this plan of correction. Additionally, the remaining neighborhoods will be audited weekly for 60 days. Identified non-compliance will be immediately rectified. Additionally, audit results will be reviewed by the Director of Nursing and trends identified. The outcomes and results will be reported to the quality assurance committee by the Director of Nursing for further review and recommendations that may include further education, disciplinary action, etc.</p> <p>The Director of Nursing will be responsible for this plan of correction</p> <p><i>F279 POC Accepted 4/13/10 [Signature]</i></p>	<p>8/25/2010</p> <p>8/30/2010</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X5) DATE 30 August 2010
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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 279	Continued From page 1 1. Per staff interview and record review, the facility did not develop a care plan addressing care and services related to the diagnoses of anemia or renal failure for Resident #1. Per record review, Resident #1 had symptoms due to anemia and renal failure requiring specialist consultation, physician ordered lab testing and treatments, and hospital admissions in January 2010 and continuing through March 2010. This was confirmed in interview on 8/11/10 at 2:40 PM with the Nursing Supervisor. Also confirmed at this time was that the resident's care plan does not address specific interventions and monitoring activities required for care of the resident's anemia and renal failure.	F 279	F280 The Vermont Veterans' Home requests an IDR for F 280. It is unclear as to why the surveyor believes that the Veteran and next of kin did not participate in Veteran #1's comprehensive care plan. Per the statement of deficiencies under F 280 "Right to Participate Planning Care", it states "the resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F 279 § 483.20 states a facility must use the results of the assessments to develop, review and revise the resident's comprehensive plan of care. The interpretive guideline states that "an interdisciplinary team, in conjunction with the resident, resident's family, surrogate or representative, as appropriate, should develop quantifiable objectives for the highest level of function. . . ." Interpretive guideline § 483.10(d) (3) further states "Participates in planning care and treatment" means that the resident is afforded the opportunity to select from alternative treatments. This applies to both initial decisions about care and treatment and to decisions about changes in care and treatment. The Vermont Veterans' Home offers opportunities for Veterans/Members, and when legally appropriate, designated representatives to contribute to comprehensive care plans per our policy and procedure and actual practices. In the case of Veteran #1, comprehensive care plan meetings were held on 17 February 2009 (Veteran #1's daughter attended via phone conference), 25 August 2009 (daughter attended in person), 17 November 2009 (daughter attended in person) and 26 January 2010 (daughter attended in person). The VVH is attaching attendance sheets to support our assertion.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2010
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/11/2010
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F 280	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to revise the plan of care to reflect the current status and needs of 1 applicable resident. (Resident #1) Findings include: 1. Per record review, the care plan for Resident #1 was not revised to address actual hypoglycemic episodes. The resident had at least four hypoglycemic episodes (a blood glucose less than 70 milligrams/deciliter) in January and February, 2010. Per record review, laboratory testing documented the following blood glucose levels: On 1/27/10 blood glucose of 60 mg/dL; on 2/1/10 blood glucose of 38 mg/dL; on 2/3/10 blood glucose of 20 mg/dL; and on 2/22/10 blood glucose of 63 mg/dL. This was confirmed in interview on 8/11/10 at 2:40 PM with the Nursing Supervisor. Also confirmed at this time was that the resident's care plan does not address specific interventions and monitoring activities for the management of hypoglycemic episodes.	F 280	The Vermont Veterans Home reiterates: We dispute F 280 and request its removal from the statement of deficiencies. 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: Veteran/member #1 has expired prior to the 8/11/2010 investigation by Licensing and Protection. The Veterans death was not as a result of these deficiencies and the facility is unable to intervene now on his/her behalf. All Veterans/Members on American Way with hypoglycemic episodes have the potential to be affected by this alleged deficient practice. The following systemic changes have been made to ensure that the identified practice does not recur: The clinical care coordinator of American Way has received supervisory education. All Veterans/Members on American Way with hypoglycemic episodes have been identified and care plans reviews have occurred. Additionally, The DNS administratively directed the Clinical Care Coordinators to meet their job specifications and the responsibility to ensure appropriate care through coordination and provision of any necessary services is provided to attain or maintain the Veteran's highest practicable physical, mental, and psychosocial, well being. The Director of Nursing or designee will audit weekly, for 60 days, five records of Veterans/Members with hypoglycemic episodes to ensure this plan of correction is implemented and effective. Identified non-compliance will be immediately rectified. Audit results will be reviewed by the Director of Nursing or designee and trends identified. The outcomes and trends will be reported to the quality assurance committee by the Director of Nursing for further review and recommendations that may include further education, disciplinary action, etc...	8/11/2010
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide services in accordance with professional standards of practice or follow a physician's orders for 1 applicable resident. (Resident #1) Findings include:	F 281	The Director of Nursing is responsible for this plan of correction.	

F280 POC Accepted as circled above 9/13/10 Ametarn

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F 281	Continued From page 3 1. Per staff interview and record review, the facility failed to administer two doses of medication and obtain laboratory testing as prescribed by the physician to Resident #1. The physician order dated 1/28/10 was for Aranesp 300 microgram (mcg) subcutaneously every other week for hemoglobin (Hgb) less than 12 grams; Complete Blood Count (CBC) every other week prior to Aranesp. (Aranesp is a medication prescribed to increase red blood cell production in the body.) The medication order was transcribed on 1/28/10 by Nurse #1 onto the Medication Administration Record (MAR) of Resident #1 without a start date. Then Nurse #2 transcribed the order to the February MAR without verifying that the first dose had not been given and without indicating the next dosing date. Consequently the resident did not receive two doses of the medication or have the CBC lab test done before the transcription error was identified on 2/22/10 when the resident was hospitalized for treatment of anemia. At the time of admission to the hospital the resident's Hgb was 8.3 grams/deciliter (g/dL). Normal hemoglobin range is 14 to 18 g/dL. The physician's order transcription error was confirmed by the former facility Director of Nursing (DNS) on February 26, 2010 in the facility investigation document and reconfirmed on 8/11/10 at 2:40 PM with the Nursing Supervisor. Lippincott Manual of Nursing Practice (9th ed.) Walter, Kluwer Health/Lippincott Williams & Wilkins, pg. 17.	F 281	F281 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: Veteran/member #1 has expired prior to the 8/11/2010 investigation by Licensing and Protection. The Veterans death was not as a result of these deficiencies and the facility is unable to intervene now on his/her behalf. All Veterans/Members on American Way with medications and lab work ordered on an other than daily basis have the potential to be affected by this alleged deficient practice. The following systemic changes have been made to ensure that the identified practice does not recur: The clinical care coordinator of American Way has received supervisory education. All Veterans/Members on American Way have had their MARs and physician orders reviewed by the clinical care coordinator to ensure that all medications/treatments on other than a daily schedule have been correctly documented and transcribed (30 August 2010). The policy and procedure for Medication Transcription was reviewed and revised in May 2010 by the DNS. Staff was educated May 2010 and new facility nurses are educated during new hire orientation on the Medication Transcription policy and procedure. Additionally, The DNS administratively directed the Clinical Care Coordinator s to meet their job specifications and the responsibility to ensure appropriate care through coordination and provision of any necessary services is provided to attain or maintain the Veteran's highest practicable physical, mental, and psychosocial, well being. The Director of Nursing or designee will audit weekly, for 60 days, five medication administration records and physician orders on all neighborhoods to ensure this plan of correction is implemented and effective. Identified non-compliance will be immediately rectified. Audit results will be reviewed by the Director of Nursing or designee and trends identified. The outcomes and trends will be reported to the quality assurance committee by the Director of Nursing for further review and recommendations that may include further education, disciplinary action, etc... The Director of Nursing is responsible for this plan of correction. F281 POC Accepted 9/13/10 P. MONTGOMERY	8/11/2010 8/30/2010 5/2010
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333	F 333 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: Veteran/member #1 has expired prior to the 8/11/2010 investigation by Licensing and Protection. The Veterans death was not as a result of these deficiencies and the facility is unable to intervene now on his/her behalf. All Veterans/Members on American Way with medications and lab work ordered on an other than daily basis have the potential to be affected by this alleged deficient practice.	8/11/2010

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F 333	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that residents are free of any significant medication errors for one applicable resident. (Resident #1) Findings include: 1. Per staff interview and record review the facility failed to administer two doses of medication as prescribed by the physician to Resident # 1. The physician's order dated 1/28/10 was for Aranesp 300 microgram (mcg) subcutaneously every other week for hemoglobin less than 12 grams. The medication order was transcribed on 1/28/10 by Nurse #1 onto the Medication Administration Record (MAR) of Resident #1 without a start date. Nurse #2 transcribed the order to the February MAR without verifying that the first dose had not been given and without indicating the next dosing date. Consequently the resident did not receive two doses of the medication before the transcription error was identified on 2/22/10 when the resident was hospitalized for treatment of anemia. At the time of admission to the hospital the resident's hemoglobin was 8.3 grams/deciliter (g/dL). Normal hemoglobin range is 14 to 18 g/dL. This transcription and medication error was confirmed by the former facility Director of Nursing (DNS) on February 26, 2010 in the facility investigation document and reconfirmed on 8/11/10 at 2:40 PM with the Nursing Supervisor.	F 333	The following systemic changes have been made to ensure that the identified practice does not recur: The clinical care coordinator of American Way has received supervisory education. All Veterans/Members on American Way have had their MARs and physician orders reviewed by the clinical care coordinator to ensure that all medications/treatments on other than a daily schedule have been correctly documented and transcribed (30 August 2010). The policy and procedure for Medication Transcription was reviewed and revised 12 May 2010 by the DNS in order to address medication errors. Staff was educated 12 May 2010 and new facility nurses are educated during new hire orientation on the Medication Transcription policy and procedure and how to reduce medication errors. Additionally, The DNS administratively directed the Clinical Care Coordinator s to meet their job specifications and the responsibility to ensure appropriate care through coordination and provision of any necessary services is provided to attain or maintain the Veteran's highest practicable physical, mental, and psychosocial; well being. Medication errors since April 2010 have been reviewed personally by the DNS to identify trends and educational needs. Since April, 2010, The Director of Nursing or designee audits all medication error reports. Immediate on site education is provided to nurses who make medication errors to identify reasons, understanding of medication administration policy and how to avoid errors in the future. All medication errors are audited to ensure the plan of correction is effective. Identified non-compliance is immediately rectified. Audit results are reviewed by the Director of Nursing or designee and trends identified. The outcomes and trends are reported to the quality assurance committee by the Director of Nursing for further review and recommendations that may include further education, disciplinary action, etc... The Director of Nursing is responsible for this plan of correction. F333 POC Accepted 9/13/10 <i>[Signature]</i>	9/30/2010 9/12/2010 4/2010	