



VERMONT

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

May 31, 2011

Melissa Jackson, Administrator
Vermont Veterans Home
325 North Street
Bennington, VT 05201

Provider ID #:475032

Dear Ms. Jackson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on
May 4, 2011.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

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

Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure



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

PRINTED: 05/16/2011
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 05/04/2011
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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	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 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to convey the remaining funds and an accounting of the funds for three applicable deceased Residents (R#1, R#2, and R#3) within 30 days of their death. Findings include: Per review of three records of deceased residents (R#1, R#2, R#3) the time frame for return of funds and a final accounting exceeded thirty days. For two of the three residents the funds were returned in forty-seven days and for the third resident funds were returned in forty-three days. In an interview with the Administrator on 5-4-11 at 12:05 PM she stated that the facility practice is to return funds for deceased residents at the end of the following month, which may exceed thirty days. This was confirmed with a representative of the Billing Dept at 12:10 PM on 5-4-2011.	F 160	F160 <u>Corrective Action:</u> The Funds in the Resident Trust Accounts for R31, R32, and R#3 have been returned to their estates. <u>Other Residents:</u> All Resident who maintain funds in a Resident Trust Account are at risk. <u>Systemic Changes:</u> The facility policy on Conveyance of Funds Upon Resident Death (attachment A) has been updated. All Business Office staff have been educated on the facility policy and F Tag 160(Attachment A1) <u>Monitoring:</u> The Administrator or designee will conduct weekly audits of Resident Trust Accounts for all deceased residents x 60 days and then monthly until 100% compliance is demonstrated through the audits. (Attachment A3) Audit findings will be reported at the bimonthly QA Meeting <u>Compliance Date:</u> June 1, 2011	
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280	<i>Filbo POC Accepted 5/24/11 S. Simmons RN / J. Montanari</i>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Melissa A Jackson BSW, LNA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>5/25/11</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 280 SS=D	<p>Continued From page 1</p> <p>PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to revise the care plan to reflect the current status for 1 applicable resident (Resident #169). Findings include:</p> <p>1. Per observation on 05/02/11 and on 05/03/11 at 1:30 PM and 11:45 AM respectively, Resident #169 was not wearing a splint device for both hands or sitting in an electric wheel chair. Per Interview on the morning of 05/05/11 resident #169 stated that "I use the splints at night only and like the chair that tilts".</p>	F 280	<p>F280</p> <p><u>Corrective Action:</u> Veteran #169 care plan was updated on 5/4/11 to reflect his preference to wear hand splints at night and for a nonelectric tilt wheelchair.</p> <p><u>Other residents:</u> Residents requiring assistive devices and wheelchairs are at risk.</p> <p><u>Systemic Changes:</u> Staff education will be performed by the staff educator and unit managers on importance of maintaining an updated care plan with Resident's current preferences and therapy recommendations.</p> <p><u>Monitoring:</u> Monthly random audit (Attachment B) will be performed by nursing staff to ensure that applicable assistive devices are indicated on the care plan with current recommendations and resident preference. Nurse Manager will provide DNS a copy of the audit monthly; DNS will report results to Quality Assurance committee bimonthly and upon 100% compliance for 3 months, will report to the Quality Assurance Committee 2 additional quarters.</p> <p><u>Compliance Date:</u> June 1, 2011</p> <p><i>F280 PDC Accepted 5/26/11 S.EMMONS/RN / J.MOYER/RN</i></p>	

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F 280	Continued From page 2 Per record review on 05/04/11, the care plan listed under rehab dated 03/07/11 states 'will tolerate bilateral hand splints' and the ADL's (Activities of Daily Living) care plan states [vet] is more comfortable in his electric wheel chair'. Per interview on 05/04/11 at 9:54 AM, LNA (Licensed Nursing Assistants) staff confirmed that the resident uses a hand splint only at night now, but uses a pillow now and the resident likes the use of a 'tilt wheel chair which is more comfortable. Per interview on 05/04/11 at 10:30 AM the DNS (Director of Nursing Services) confirmed the care plan is not revised to reflect the current use of splints and mobility devices.	F 280	F282 <u>Corrective Action:</u> On 5/4/11 the staff was educated on the purpose of the return clock for Resident #169 and the need for consistency in implementing the intervention of the return clock as a method to reduce anxiety. (Attachment C1) <u>Other Residents:</u> All Resident requiring specific behavioral intervention care plans are at risk. <u>Systemic Changes:</u> Staff education will be performed by the staff educator and unit managers on importance of following specific care plan interventions for behavior and anxiety. <u>Monitoring:</u> Monthly random audit (see Exhibit C2) will be performed by nursing staff to ensure that the interventions specified on behavioral care plans are followed and effective. Nurse Manager will provide DNS a copy of the audit monthly; DNS will report results to Quality Assurance committee bimonthly; after 3 months of 100% compliance, will report to the Quality Assurance Committee 2 additional quarters. <u>Compliance Date:</u> June 1, 2011 F282 POC Accepted 5/26/11 SEMMAWRN/DMCARN		
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 upon observation, record review and interview, the facility failed to implement a timing device in accordance with the resident's total plan of care for one applicable resident. (Resident #169). Findings include: 1. Per observation for the 3 days of survey, a picture of a plastic clock in which the arms are moveable, was noted on the outside of Resident #169's doorway. Per record review the care plan directs staff to "please indicate the time you will return, on my [plastic picture] clock, reset my	F 282			

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F 282	Continued From page 3 return clock". Per interview on 05/04/11 at 9:45 AM , 3 LNA's stated to the nurse surveyor when asked about the clock " we don't know what it is for, haven't used it", although one LNA stated stated 'I think we used it one at time'. Per interview on 05/04/11 at 10:30 Am the DNS confirmed that staff failed to implement the care plan and 'should be done to lower the [vets] anxiety'.	F 282		
F 323 SS=E	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 observation and interview, the facility failed to ensure that the resident environment remained free of accident hazards. Findings include: Per observation on 5/2/11 at 2:08 PM, 4 radiators on the East Haven Unit were hot to touch, creating a potential accident hazard to residents. Infrared temperatures were obtained and were recorded as follows: Room 108 138 degrees Fahrenheit (F) Room 107 141 degrees F Hall radiator near nursing station 137 degrees F	F 323	F 323 <u>Corrective Action:</u> The water temperature on the boiler has been reduced to 120 degrees, which prevents the radiator units from becoming hot to the touch. <u>Other Residents:</u> All Residents residing on East Haven are at risk. <u>Systemic Changes:</u> Maintenance Supervisor, Nursing Supervisor or their designee will monitor radiator temperatures q shift and PRN on East Haven to ensure they do not rise above 120 degrees. Maintenance will be notified immediately when radiator temperatures exceed 120 degrees. Prior to the start of the 2011-2012 heating season non-heat conducting radiator covers will be installed on all radiators on East Haven. <u>Monitoring:</u> The Maintenance Supervisor of his designee will conduct weekly random audits (Attachment D) of the radiator temperature monitoring x 60 days and then monthly until 100% compliance is demonstrated. Audit results will be reviewed at the bimonthly QA meetings. <u>Compliance Date:</u> June 1, 2011 F323 PDC Accepted 5/26/11 SEMOURN / PIMOURN	

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F 323	<p>Continued From page 4 Hall radiator between rooms 107 - 108 137 degrees F</p> <p>The above temperatures were observed with the Unit Manager (UM) at 2:27 PM on 5/2/11 who agreed the radiators were extremely hot to touch. The UM confirmed the above temperatures. The UM stated that h/she was unaware of the hot radiators and staff would be expected to notify maintenance if they noticed hot radiators. Per interview on 5/2/11 at 2:40 PM with the Maintenance Director, h/she was not aware of high radiator temps but was aware there are issues with heat on East Haven Unit. H/she stated that there is no system to monitor radiator temperatures in rooms and relies on staff or residents to relay information.</p>	F 323	<p>F353 <u>Corrective Action:</u> Staffing levels on Veteran #125's unit has been evaluated in regard to number of Residents per staff member and acuity level.</p> <p><u>Other Residents:</u> All Residents are at risk</p> <p><u>Systemic Changes:</u> Staffing levels on all units will also be evaluated with a determination for optimal staffing based on number of Residents and acuity. Supervisors and Nurse Managers will be in-serviced by the Staff Educator, DNS or Administrator regarding maintaining optimal staffing levels. All facility staff will be educated regarding the call bell policy by the Staff Educator, Nursing Supervisors, or Department Heads.</p>	
F 353 SS=D	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this</p>	F 353	<p><u>Monitoring:</u> Optimal staffing levels will be evaluated daily by the scheduler and Nursing Supervisors for 3 months. Scheduler and Nursing Supervisors will report variances to DNS and Administrator daily. Findings will be reviewed at the bimonthly Quality Assurance committee meeting; after 3 months, will review results of staffing changes implemented and report to the Quality Assurance Committee 2 additional quarters. Continued next paged</p>	

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F 353	<p>Continued From page 5 section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to have sufficient nursing staff to provide nursing services to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident, including, but not limited to, Resident #125. Findings include:</p> <p>1. Per interview at 3:00 PM on 05/03/11 Resident #125 stated during the interview that 'call bells ring all night and keep me up and also stated that s/he 'called for bed pan and staff took 15 minutes to get there to empty it'. Per observation on 05/03/11 at 3:20 PM the staff nurse walked past and looked in a room in which the call light was on, without stopping to answer it. At 3:35 pm, 15 minutes after the light went on a LNA answered the light. Per interview at 3:37 PM the staff nurse stated 'I don' t stop [for call lights] during a med pass'. The nurse was unable to answer if there was a policy regarding not answering call lights during med pass but stated "its been that way since I worked here' Per interview later that evening, another staff nurse stated " of course I have to answer the call lights while passing meds ...there are 48 vets and 3 LNAs tonight'. Per interview on 05/04/11 at 10:30 AM the DNS confirmed that the facility is looking at new ways to schedule to fill the staffing needs and all staff are to answer the residents light when they go on..</p>	F 353	<p>F353 continued Monitoring continued: Random weekly call bell audits (Attachment E) will be performed on all units by facility leadership or designee x 4 weeks then biweekly until 100% compliance is demonstrated. Audit finding will be reported at the bimonthly Quality Assurance Committee meeting.</p> <p><u>Compliance Date:</u> June 1, 2011</p> <p><i>F353 POC Accepted 5/26/11 S. EMMONS/AMSTARA</i></p>		

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F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store and prepare food under sanitary conditions. Findings include:</p> <p>During the 5/2/11, 10:30 AM initial tour of the kitchen, the following unsanitary conditions were observed in the facility kitchen:</p> <ol style="list-style-type: none"> 1. A large floor fan currently in use in the dishwashing area was heavily soiled with dust and grease. The fan was blowing in the direction of the dishwashing line. 2. There were several broken ceramic tiles on a shelf adjacent to a soup container and a potato peeling machine. There was flaking paint and ceramic chips and a large amount of dust and debris where the tiles were missing. 3. In the walk-in refrigerator, there were 4 hotel pans containing pork noodles dated 4/28/11. Per interview with the Food Service Director at the time of observation, facility policy is to dispose of perishable foods after 3 days. Additionally, there was 1 hotel pan containing noodles and meat and 	F 371	<p>F 371</p> <p><u>Corrective Action:</u> The floor fan has been cleaned and the broken ceramic tiles have been replaced. The outdated and unlabeled food was disposed of on 4/28/11.</p> <p><u>Other Residents:</u> All residents were at risk.</p> <p><u>Systemic Changes:</u> Dietary Staff will be educated on the facility policy on fan maintenance and cleaning, ensuring all titles are secure and it good repair, the facility policy for labeling, dating, and sealing of food and the disposal of perishable food after 3 days.</p> <p><u>Monitoring:</u> The Dietary Director or designee will conduct random weekly audits x 4 weeks (Attachments F) of all fans, all wall and floor tiles. Weekly audits x 4 weeks on proper food storage to include proper labeling, dating, sealing and ensuring perishable food is disposed of within 3 days. (Attachment G). Both audits will continue biweekly after 30 days until 100% compliance is achieved. Audit findings will be reported to the bimonthly Quality Assurance Meeting.</p> <p><u>Compliance Date:</u> June 4, 2011</p> <p><i>F371 POC Accepted 5/26/11 SEMMONSRN PincotRN</i></p>	
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<p>F 371</p> <p>F 441 SS=D</p>	<p>Continued From page 7 a container of chili that was unlabeled and undated. The above observations were confirmed by the Food Service Director at the time of observation.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p>	<p>F 371</p> <p>F 441</p>	<p>F441 <u>Corrective Action:</u> Education was provided to individual nurse regarding facility policy for irrigation and dressing changes with specific emphasis on Infection Control practice. (Attachment H1)</p> <p><u>Other Residents:</u> All residents who require irrigation and dressing changes.</p> <p><u>Systemic Changes:</u> The nursing staff will be educated on the facility's infection control practices with dressing changes and irrigation. Annual Nursing Dressing Change Competencies will be instituted. (Attachment H2)</p> <p><u>Monitoring:</u> The Director of Nursing of designee will conduct a weekly random audit (Attachment H3) x 4 weeks of 1 dressing change and/or irrigation on each unit, and then biweekly until 100% compliance is achieved. Audit findings will be reported at the bimonthly Quality Assurance Meeting.</p> <p><u>Compliance Date:</u> June 1, 2011</p> <p><i>F441 POC Accepted 5/26/11 S. EMMONS RN / P. McArthur RN</i></p>	

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F 441	<p>Continued From page 8</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assure that Infection Control practice was maintained during an irrigation and dressing procedure for 1 applicable resident. (Resident #168) Findings include:</p> <p>1. Based on observation and confirmed during interview, the staff nurse failed to follow proper infection control practice by failing to wash or sanitize his/her hands between clean and dirty procedures and failing to sanitizing the bedside table after a dressing change. On 05/04/11 at 9:54 AM the staff nurse removed a soiled dressing from a supra pubic catheter wound, cleansed the area and applied a new dressing without removing the soiled gloves prior to applying the clean dressing. The nurse then removed the soiled gloves after this procedure, but failed to wash and/or sanitize his/her hands before applying new gloves for the next procedure. In addition, at the end of the procedure, the nurse did not sanitize the bedside table which contained the irrigation kit. The Nurse and the DNS confirmed at 10:15 AM infection control practice was not maintained.</p>	F 441		
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