

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 6, 2014

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

Dear Ms. Jackson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 26, 2014**. 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  
Licensing Chief

PC:jl

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

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 03/26/2014
NAME OF PROVIDER OR SUPPLIER  VERMONT VETERANS' HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 325 NORTH STREET BENNINGTON, VT 05201	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  An unannounced onsite annual recertification survey and investigation of multiple entity self-reports was conducted by the Division of Licensing & Protection from 3/24/2014 to 3/26/2014. Regulatory deficiencies were identified.	F 000	The filing of this plan of correction does not constitute an admission of guilt. Vermont Veterans Home ("the Provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported	F 225	F225 Report Allegations/Individuals  Resident #1 resides on the Dementia Unit and has no recall of this alleged incident. He is at his baseline behavior.  LNA who made the allegation has been terminated from the facility.  LNA who was accused was suspended pending the outcome of the investigation. The investigation concluded that abuse did not occur and the LNA returned to work after having education regarding abuse and reporting obligations.  Nurse (RN) had 1:1 education on abuse and reporting obligations.  Facility staff has begun to have education on the Hand in Hand program provided by CMS which began on 3/14/14 and is	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Melissa O'Hara* TITLE: BSW, MHA Administrator (X6) DATE: 4/30/14

*POC accepted M. H. G. / F. Keen RN MSN OBA 5/6/14*

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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PRINTED: 04/28/2014  
FORM APPROVED  
OMB NO. 0938-0391

TATEMENT 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 03/26/2014
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F 225	<p>Continued From page 1</p> <p>to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview the facility failed to ensure that all alleged violations involving mistreatment or abuse are reported immediately to the administrator of the facility and to other officials in accordance with State law, including to the State survey and certification agency for 1 resident of 18 identified (Resident #1). The findings include:</p> <p>1. Per record review, on 10/12/14, a Licensed Nursing Assistant (LNA) alleged that another LNA was providing care to Resident #1 and was handling Resident #1 rough manner, grabbing at Resident #1's clothing, pushed Resident #1's face into a pillow, and turning the resident abruptly causing Resident #1's legs to hit the other LNA present. Per review of the facility investigation the LNA did not report the alleged incident that occurred on 10/12/13 until 10/14/13, when the LNA reported the incident to a facility Registered Nurse (RN).</p> <p>Per record review the RN reported the 10/12/13 incident of an LNA allegedly handling Resident #1 in a rough manner, grabbing at Resident #1's clothing, pushed Resident #1's face into a pillow, and turning the resident abruptly causing Resident #1's legs to hit the other LNA present on</p>	F 225	<p>ongoing. The facility has adopted the education as part of the Dementia training program and abuse prevention.</p> <p>Every neighborhood has administrative staffs' phone numbers in addition to Hotline numbers to report abuse. As part of the education staff is made aware of this avenue for reporting abuse. In addition, information on abuse reporting are posted throughout the facility.</p> <p>The facility has an Employee Assistance Program (EAP) to assist with personal stress and job "burnout". This program is available for all employees and has been educated as part of the "Hand in Hand" education. The numbers for this program are posted throughout the facility.</p> <p>The facility has a zero tolerance policy on Abuse and will pursue discipline for any individual who is not cleared at the conclusion of the investigations and for any individual who does not report abuse.</p> <p>The Administrator or designee have begun to review all allegation investigations and follow all staff members being investigated to ensure discipline is conducted as</p>	

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F 225	Continued From page 2 10/16/13 to the facility Administration.  Per review of the facility policy and procedure titled; Abuse Prevention Policy under the section of reporting a crime. The policy states "All events that cause the reasonable person suspicion do not result in a serious bodily injury to a resident the report will be made immediately but no later than 24 hours after forming that suspicion." Also under the section of Mandated reporters, the facility policy indicates that "All nursing home employees are considered mandatory reporters."  Per review of the facility internal investigation and confirmed on 3/24/14 by the facility Administrator, the LNA and the RN did not report allegations of abuse in a timely manner consistent with the regulatory requirements for allegations of abuse and also the facility Abuse policy and procedure.	F 225	All reportable incidents are reviewed upon completion and data from the process is brought to the QAPI meeting every two months for review, this in an ongoing process that will be continued.  The Administrator is ultimately responsible to ensure that allegations of Abuse, Mistreatment and Neglect are reported per the Abuse Policy.  Compliance Date: April 19, 2014	
F 371 SS=E	483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  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  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure that food is stored, prepared, distributed and served under sanitary	F 371	F371 Food Storage/prepare/serve-Sanitary  The vent and fan in the kitchen area near the dishwashing are was cleaned. All other fans and vents in the kitchen were cleaned.  All fans and vents facility wide were audited and systematically cleaned neighborhood by neighborhood. All fans and vents are on a cleaning schedule.  Housekeeping staff were educated on the importance of adhering to the cleaning schedule on (add date) and will be ongoing.	

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F 371	Continued From page 3 conditions. The findings include:  Per direct observation on 3/24/14 at approximately 10:40 AM, a large black fan was noted to be in the dishwashing area, facing the clean dish area. The fan was covered with dirt and dust and was oscillating directly on the clean area which contained glasses and cups.  Per direct observation on 3/24/14 at approximately 10:40 AM, in the dishwashing area in the kitchen directly above the clean side of the dishwasher, there is a vent that was thickly coated with dirt, grease and dust.  Per interview with the Dietary Manager, he/she confirmed after direct observation that the large black fan was on and covered with dirt and dust blowing directly on to the clean dish area containing cups and glasses meant for resident use.  Per Interview with the Dietary Manager, he/she confirmed after direct observation that in the dish wash area in the kitchen directly above the clean side of the dishwasher, there is a vent that was thickly coated with dirt, grease and dust. The Dietary Manager confirmed it was directly over the clean side of the dishwasher.	F 371	The Maintenance Director will conduct weekly random audits of facility fans and vents to ensure that they are clean.  The administrator or designee will conduct random audits of fans and vents to ensure the cleaning schedule is being followed.  Data from the audits will be brought to the QAPI meeting every other month for six months or until the committee determines resolution.  The administrator is ultimately responsible to ensure food is prepared under sanitary conditions.  Compliance Date: April 19, 2014	
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	F465 Safe/Functional/Sanitary/Comfortable Environment  The Electric Wheelchair was removed from the hallway upon discovery and was charged in the SDC room at the end of the corridor.  The oxygen tank was removed from the walker upon All electric wheelchairs have been removed from the corridors and are charged in designated areas on the units.	

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F 465 Continued From page 4  
This REQUIREMENT is not met as evidenced by:  
Based on observation and interview the Facility failed to assure a safe environment for residents, staff and the public. Findings include:

1. Per observations on the American Unit for two days of survey, a power wheel chair was observed nearly blocking the exit door and parked in front of the fire pull box, as well as other equipment, creating potential hazard was present in the hallway. A sign on the glass door notes [a circle with a line through it] "this is a no storage zone - no stuff".

Also, a four-wheeled walker had an oxygen tank hanging off the front bar.

Per observation and interview with the Maintenance Director, Administrator, and Assist DNS at 2:40 PM on 03/25/14, stated that per life safety codes no items are to be stored in the hallways for more than 30 minutes and that staff are trained on this concern. S/he confirmed that the oxygen tank on the walker, which could easily be tipped and the power wheel chair blocking the egress, is a potential safety issue.

F 465

No oxygen tanks are used on walkers and all have been placed in holders.

The Maintenance Director will conduct random audits of Electric Wheelchairs and Oxygen tanks to ensure proper storage and oxygen holders are being used.

The administrator or designee will conduct random audits to ensure compliance in this area. Data from the audits will be brought to the QAPI meeting every other month for six months or until the committee has determined resolution.

The administrator is ultimately responsible to ensure that the environment is safe.

Compliance Date: April 19, 2014