

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 8, 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 **April 1, 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,



Frances L. Keeler, RN, MSN, DBA
Assistant Division Director
State Survey Agency Director

FK:jl

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

PRINTED: 04/14/2014
FORM APPROVED
OMB NO. 0938-0391

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Licensing and
Protection

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 04/01/2014
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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 on-site complaint investigation was conducted by the Division of Licensing and Protection on 3/31 - 4/1/14. The following regulatory violations 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 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of	F 203	F203 Notice Before Transfer/Discharge Resident #1 no longer resides at the facility. At this time there are no notices of Discharge for any resident who resides at VVH. For all future Discharge Notices the Assistant Administrator or Designee will review them before they are sent to ensure that the 30 day notice period is being followed. The Administrator will conduct random audits of the Discharge Notices monthly to ensure that the 30 day notice period is adhered to. Data from the audits will be brought to the QAPI meeting every other month for six months or until the committee determines resolution.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Melissa A Jackson BSW LNA</i>	TITLE Administrator	(X6) DATE 4/24/14
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POC accepted T. Daugherty / E. Keller RN/NSU OBA 5/8/14

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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F 203	<p>Continued From page 1</p> <p>this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by:</p> <p>Based upon interview and record review, the facility failed to ensure 1 of 3 residents [Resident #1] of the sample group was given the required 30 days notice prior to discharge from the facility. Findings include:</p> <p>Per record review of Physician Orders for Resident #1 dated 1/30/14, it states "discharge patient from VVH [Vermont Veterans Home]". Per record review and confirmed during interview with the facility's Administrator [ADM] on 4/1/14, the first discharge notice for Resident #1 is dated 2/10/14. The notice was deemed not to include all the information required by state and federal regulations, and was redrafted and dated 3/3/14. The 3/3/14 notice states "we intend to discharge you from this facility on Feb. 10, 2014". Per interview with the ADM and the Social Worker on</p>	F 203	<p>The Administrator is ultimately responsible to ensure that residents have a 30 day notice of Discharge.</p> <p>Compliance Date: April 27, 2014</p> <p>F207 Equal Practices Regardless of Payment Source</p> <p>Resident #1 no longer resides at the facility.</p> <p>There are currently no residents who are on MLOA who have exceeded their bed hold.</p> <p>Residents who are transferred to the hospital are on a bed hold. All residents are given the opportunity to hold the bed and extend the bed hold if they so wish. All residents are given the opportunity to reapply for residence at the VVH when there level of care meets facility admission criteria.</p> <p>The Assistant Administrator will review all residents who are on a Bed Hold to ensure</p>		

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F 203 F 207 SS=D	<p>Continued From page 2 4/1/14 at 10:47 A.M. there is no documentation that Resident #1 received the required notice of discharge 30 days before h/her discharge order was written.</p> <p>483.12(c) EQUAL PRACTICES REGARDLESS OF PAYMENT SOURCE</p> <p>A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment.</p> <p>The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in §483.10(b)(5)(i) and (b)(6) describing the charges; and the State is not required to offer additional services on behalf of a resident other than services provided in the State plan.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to treat all residents alike when making transfer and discharge decisions for 1 of 3 residents [Resident #1] of the sample group. Findings include:</p> <p>Per record review of Physician Orders for Resident #1 dated 1/30/14 read "discharge patient from VVH [Vermont Veterans Home]". Per interview with the facility's Administrator [ADM] on 3/31/14 at 10:47 A.M. Resident #1 was discharged from the facility because the facility could not provide the treatment the resident was anticipated to require when h/she was discharged</p>	F 203 F 207	<p>that the Bed Hold is conducted per policy and Regulation.</p> <p>The Administrator will conduct random monthly audits of Residents on a Bed Hold to ensure that compliance is being adhered to.</p> <p>The Administrator is ultimately responsible to ensure all residents are treated equally.</p> <p>Compliance Date: April 27, 2014</p>	

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F 207	<p>Continued From page 3</p> <p>from the hospital. The ADM reported that the resident had received a stent to improve kidney function, and that the other treatments that the facility provided to the resident prior to h/her hospitalization might interfere with the stent's function. The ADM reported Resident #1's primary doctor had been in communication with the hospital staff treating Resident #1, and was to speak with staff at the hospital today [3/31/14] regarding treatment requirements.</p> <p>Per interview with the facility's Assistant Director of Nursing Services [ADNS] on 3/31/14 at 11:01 A.M., the ADNS stated Resident #1's treatment can be complicated because of forcing fluid back up into the kidneys and the resident now had a stent. The ADNS stated one of the reasons for Resident #1's discharge was the facility's staff may not have the expertise to give [Resident #1] the level of treatment that h/she needs if h/she returned.</p> <p>Per record review, Physician Notes for Resident #1 dated the day of discharge reads "patient is discharged from the VVH at the request of the administration for administrative reasons". Per interview with the Social Worker [SW] on 3/31/14 at 4:50 P.M. Resident #1 had a large outstanding bill at the facility which had been discussed with the resident a number of times over the past year. The SW reported the facility had attempted to discharge Resident #1 for lack of payment before, but h/her physical condition would worsen, and the facility would rescind the discharge. The SW stated h/she knew of no resident who was discharged from the facility before due to lack of payment, but that the facility "hadn't had anybody here that had that large a bill [as Resident #1's]."</p>	F 207		

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F 207	Continued From page 4 Per interview with Resident #1's primary physician on 4/1/14 at 3:30 P.M. the physician reported h/she had had very little contact with staff treating Resident #1 at the hospital and could not recall the last time h/she had spoken with them. The physician reported that the resident's discharge was for "administrative reasons" and was not based on medical condition, and h/she was not aware of any medical condition preventing Resident #1 from returning to the facility. The facility's ADM was present during the interview with Resident #1's physician, and confirmed per the physician's statement and the physician progress notes there was no documented medical reason for the resident's discharge, and that the only confirmed documented reason for Resident #1's discharge was for administrative reasons, which was Resident #1's previous lack of payment. The ADM also confirmed the SW's report that Resident #1 was the only resident from the facility who had been discharged for lack of payment. 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 interview and record review, the facility failed to follow the interventions in accordance with the Care Plan for 1 of 3 residents [Resident #2] of the sample group,	F 207	F282 Services by Qualified Person Per the Care Plan Resident #2 has expired. All residents who have experienced a fall in the past 30 days had a Fall Risk Assessment completed. In addition, their care plans were reviewed to ensure that all interventions are being followed as documented. Nursing staff will have education regarding following the plan of care beginning on April 25, 2014 and will be ongoing. The Assistant Director of Nurses or designee will conduct random weekly audits of residents who are a fall risk to ensure that the plan of care is being followed. The Director of Nurses or designee will conduct a random sampling from the audit to ensure compliance to the care plan. Data from the audits will be brought to the QAPI meeting every other month or until the	
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	<p>Continued From page 5 resulting in injury to the resident. Findings include:</p> <p>Resident #2, whose diagnoses include muscle weakness, abnormality of gait, and dementia, is identified as at risk for falls in h/her Care Plan. The list for reasons the resident is a fall risk include "history of falls with fracture" and that the resident "has been known to fall asleep while standing." The first goal listed in the Care Plan is Resident #2 "will not sustain any serious injuries related to falls" and the first intervention listed toward achieving that goal is "rehab evaluation and treat as indicated". A rehabilitation evaluation was ordered for Resident #2, with the final report listing: "Precautions-constant supervision due to cognition, fall risk and safety awareness" and the resident was discharged from PT (Physical Therapy) on 1/30/14 with the "discharge recommendation: wheelchair for transport".</p> <p>Per review on 4/1/14 of the facility's A&I [Accident & Incident] Staff Statement, and confirmed by the facility's ADM [Administrator], LNA #1 was ambulating Resident #2 on 3/2/14 to the bathroom without a walker or wheelchair when the LNA noticed another resident urinating on the floor. Per LNA #1's written statement "I put [Resident #2] by the nurses station desk to show [Resident #3] to the bathroom." Nursing Notes from the nurse present at the station on 3/2/14 document Resident #2 "stood banging on desk, [Res. #2] walked 5 feet then turned and fell sideways". Per record review of Emergency Department notes from the Southwestern Vermont Medical Center where Res. #2 was later taken on 3/2/14, the resident suffered a "fracture of [h/her] right femoral neck" from the fall.</p>	F 282	<p>committee determines resolution.</p> <p>The Director of Nursing is ultimately responsible to ensure that the plan of care is being followed.</p> <p>An IDR is being filed for this deficiency</p> <p>Compliance Date: April 27, 2014</p>	

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F 282	Continued From page 6 Per review of records and the facility's investigation, and confirmed during interview with the Administrator [ADM] and Assistant Director of Nursing on 4/1/14, the facility's Incident Report documents 'the type of incident: observed fall while ambulating' and that Nurse #1 documented the resident walked 5 feet before h/she fell. There is no documentation that a walker or wheelchair was used with Resident #2 per PT's treatment recommendation. Additionally, there is no documentation in nursing notes, staff statements from LNA #1 or Nurse #1, or in the facility's investigation and root cause analysis that the nurse was asked or engaged in supervising Resident #2 when LNA #1 left the resident without support at the desk, or that the nurse attempted or was in the physical proximity to implement 'hand hold assistance' to the resident, in order to prevent the resident ambulating alone for 5 feet, turning, falling, and fracturing h/her hip.	F 282	F323 Free of Accident Hazards/Supervision/Devices Resident #2 has expired. All residents who have experienced a fall in the past 30 days had a Fall Risk Assessment completed. In addition, their care plans were reviewed to ensure that all interventions are being followed as documented.	
F 323 SS=G	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 upon interview and record review, the facility failed to ensure that each resident receives adequate supervision and assistance devices to prevent avoidable accidents for 1 of 3	F 323	Nursing staff will have education regarding following the plan of care beginning on April 25, 2014 and will be ongoing. The Assistant Director of Nurses or designee will conduct random weekly audits of residents who are a fall risk to ensure that the plan of care is being followed. The Director of Nurses or designee will conduct a random sampling from the audit to ensure compliance to the care plan. Data from the audits will be brought to the QAPI meeting	

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F 323	Continued From page 7 residents [Resident #2] of the sample group, resulting in injury to the resident. Findings include: Resident #2, whose diagnoses include muscle weakness, abnormality of gait, and dementia, is identified as at risk for falls in h/her Care Plan. The list for reasons the resident is a fall risk include "history of falls with fracture" and that the resident "has been known to fall asleep while standing." Per record review the facility's Elopement Evaluation for Resident #2 dated 2/28/14 the resident has "complete confusion", and an Incontinence Evaluation lists Resident #1's mental status as "confused, dementia, repeated prompting needed". A risk identifying tool the facility uses to measure fall risk [the Morse Fall Scale] dated 2/28/14 identifies Resident #2 as having a "history of falling, nurse assist for ambulation, impaired gait, and overestimates or forgets limitations." The Morse fall risk scale scores Resident #2 as a '75', with anything greater than '45' considered a "high risk". [Per 'Preventing Patient Falls: Janice M. Morse, PhD' those who are rated as fall-prone do not have accidents, because we expect them to trip or slip. Because these patients have a poor gait, impaired balance, are cognitive impaired...we expect them to trip or to slip, to lose their balance, and to fall. In other words, they are an "accident about to happen," and it is the responsibility of caregivers to ensure the safety of those who score as fall-prone on the fall screening tools."] (http://www.springerpub.com/samples/9780826103895_chapter.pdf - Preventing Patient Falls) Per record review, Nursing Notes dated 1/5/14 report Resident #2 "ambulating slower and	F 323	every other month or until the committee determines resolution. The Director of Nursing is ultimately responsible to ensure that residents are free of accidents. An IDR is being filed for this deficiency.		

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F 323	<p>Continued From page 8</p> <p>slower, and not moving/ ambulating independently. Staff requesting PT/OT [Physical Therapy/Occupational Therapy] evaluation for wheelchair." A rehabilitation evaluation was ordered for Resident #2, with the final report listing: "Precautions- constant supervision due to cognition, fall risk and safety awareness" and the resident was discharged from PT on 1/30/14 with the "discharge recommendation: wheelchair for transport". Per record review the facility's LNA [Licensed Nursing Assistant] daily flow sheet for February and March 2014 list Resident #2's means of locomotion as "walker, wheel chair" with one person assisting. The daily flow sheet marks a walker or wheelchair used with Resident #1 every day on every shift.</p> <p>Per review on 4/1/14 of the facility's A&I [Accident & Incident] Staff Statement, and confirmed by the facility's ADM [Administrator], LNA #1 was ambulating Resident #2 on 3/2/14 to the bathroom without a walker or wheelchair when the LNA noticed another resident urinating on the floor. Per LNA #1's written statement "I put [Resident #2] by the nurses station desk to show [Resident #3] to the bathroom." Nursing Notes from the nurse present at the station on 3/2/14 document Resident #2 "stood banging on desk, [Res. #2] walked 5 feet then turned and fell sideways". Per record review of Emergency Department notes from the Southwestern Vermont Medical Center where Res. #2 was later taken on 3/2/14, the resident suffered a "fracture of [h/her] right femoral neck" from the fall.</p> <p>Per review of records and the facility's investigation, and confirmed during interview with the Administrator [ADM] and Assistant Director of Nursing on 4/1/14, the facility's Incident Report</p>	F 323		

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F 323	Continued From page 9 documents 'the type of incident: observed fall while ambulating' and that Nurse #1 documented the resident walked 5 feet before h/she fell. There is no documentation that a walker or wheelchair was used with Resident #2 per PT's treatment recommendation. Additionally, there is no documentation in nursing notes, staff statements from LNA #1 or Nurse #1, or in the facility's investigation and root cause analysis that the nurse was asked or engaged in supervising Resident #2 when LNA #1 left the resident without support at the desk, or that the nurse attempted or was in the physical proximity to implement 'hand hold assistance' to the resident, in order to prevent the resident ambulating alone for 5 feet, turning, falling, and fracturing h/her hip. Per interview with the facility's ADM on 4/1/14 at 3:00 P.M. the ADM confirmed it was reasonable to conclude, based upon the staff's familiarity of the resident, the staff's knowledge of Resident #2's diagnoses of muscle weakness, abnormality of gait, and dementia; the resident's history of falls; the evaluations noting the resident's "complete confusion" and the documentation that it was "difficult for [h/her] to follow direction" and "repeated prompting needed", and that a walker or wheelchair was recommended to ambulate the resident but was not used; in addition to the initial reason why the resident was ambulated- the resident's urgent need of the bathroom- that the resident would not have remained standing at the nurses desk until the LNA returned, and staff should have recognized and identified the potential for an accident or incident and acted accordingly to prevent it but did not.	F 323		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475032	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 4/1/2014
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NAME OF PROVIDER OR SUPPLIER VERMONT VETERANS' HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 325 NORTH STREET BENNINGTON, VT
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 280	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO 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 upon interview and record review, the facility failed to revise the Care Plan for 1 of 3 residents [Resident #2] of the sample group to accurately reflect the resident's physical and mental status. Findings include:</p> <p>Resident #2, whose diagnoses include muscle weakness, abnormality of gait, and dementia, is identified as at risk for falls in h/her Care Plan. Included in the list of factors why Resident #2 is at risk is Resident #2 "Ambulates Independently". Per record review, Nursing Notes dated 1/5/14 report Resident #2 "ambulating slower and slower, and not moving/ambulating independently." A rehabilitation evaluation was ordered for Resident #2, and the resident was discharged from Physical Therapy on 1/30/14 with the "discharge recommendation: wheelchair for transport". Per record review, the facility's LNA [Licensed Nursing Assistant] daily flow sheet for February and March 2014 list Resident #2's means of locomotion as "walker, wheel chair" with one person assisting. The daily flow sheet marks a walker or wheelchair used with Resident #1 every day on every shift.</p> <p>Per review on 4/1/14 of the facility's A&I [Accident & Incident] Staff Statement, and confirmed by the facility's ADM [Administrator], LNA #1 was ambulating Resident #2 on 3/2/14 to the bathroom without a walker or wheelchair when the LNA noticed another resident urinating on the floor. Per LNA #1's written statement "I put [Resident #2] by the nurses station desk to show [Resident #3] to the bathroom." Nursing Notes from the nurse present at the station on 3/2/14 document Resident #2 "stood banging on desk, [Res. #2] walked 5 feet then turned and fell sideways". Per record review of Emergency Department notes from the Southwestern Vermont Medical Center where Res. #2 was later taken on 3/2/14, the resident suffered a "fracture of [h/her] right femoral neck" from the fall. The resident underwent hip surgery in the hospital and returned to the facility on 3/7/14.</p> <p>Per record review, 3 days after Resident #2 returned to the facility h/she was given another PT (Physical Therapy) evaluation. The evaluation's 'Neuromuscular Functional Assessment' records "manual wheelchair for</p>
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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

The above isolated deficiencies pose no actual harm to the residents

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NAME OF PROVIDER OR SUPPLIER VERMONT VETERANS' HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 325 NORTH STREET BENNINGTON, VT
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 280

Continued From Page 1

primary mode of mobility? -yes".

Per record review, though Nursing Notes reported on 1/5/14 that Resident #2 was "not moving/ambulating independently", LNA flow sheets recorded a walker or wheelchair with one person assisting used with Resident #2 every day on every shift for February 2014 up to the resident's fall and fracture on 3/2/14, and PT evaluations both before and after the fall recommend a wheelchair for transport or as the "primary mode of mobility", Resident #2's Care Plan continued to assess the resident as "ambulating independently", with the Care Plan being reviewed 2/26/14, the day of the fall on 3/2/14, the day the resident returned from the hospital and surgery on 3/7/14, and again on 3/11/14, a day after the second PT evaluation, with no assessment revision to reflect the resident's inability to ambulate independently.

*This is an "A" level citation. While the facility is required to correct the identified issue, a written Plan of Correction is not required.