

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

PRINTED: 04/27/2009  
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 04/20/2009
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 CORRECTIVE ACTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  An unannounced onsite complaint investigation was completed on 4/20/09 by the Division of Licensing and Protection.	F 000	F223 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:	
F 223 SS=D	483.13(b), 483.13(b)(1)(i) ABUSE  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure 1 resident was free from physical abuse (Resident #1). Findings include:  Per interview on 4/20/09 at 3:00 PM, Resident #1 stated that on 4/11/09 he/she was hit repeatedly with a cane by Resident #2, who was the roommate at the time. Per record review, and confirmed during an interview with the DNS (Director of Nursing Services) at 2:30 PM on 4/20/09, Resident #2 demonstrated aggressive behavior and assaulted another resident on 4/9/09, throwing an object and striking that resident in the head. Per review of nurses' notes for Resident #2, since admission in March 2009, Resident #2 had been using his/her cane as a weapon. A nurses' note dated 3/6/09 states "...earlier waving cane at staff angrily." A nurses' note dated 3/8/09 states "...[Resident] swung his cane at her [staff], yelling ...no redirecting of behaviors." A nurses' note dated 3/16/09 states "...Resident continued to swing and hit with cane	F 223	Resident #1 was separated from Resident #2 and offered counseling. Resident #2 was moved to a private room on another unit.  Resident #2's plan of care was reviewed and the comprehensive care plan updated. As part of this review, the rehabilitation department evaluated the resident's ambulation abilities and recommended a walker in place of a cane. Hence, the cane was removed. Additionally, resident #2's care plan was revised to develop a plan for his/her behavioral issues.  All residents with behavioral issues have the potential to affect the well-being of peers and staff.  The following systemic change has been made to ensure that the identified practice does not recur. All residents with behavioral symptoms were reviewed and if indicated, their care plan revised. Clinical staff were re-educated regarding the assessment and development of care plans to address potential behavioral issues that may impact the well-being and safety of peers and staff.  The Director of Quality Assurance will audit weekly, for 60 days, the shift-to-shift report against comprehensive care plans to ensure the effective implementation of this plan of correction. Identified non-compliance will be immediately rectified. Audit results will be reviewed by the Administrator or designee and trends identified. The outcomes and trends will be reported to the quality assurance committee by the Director of Quality Assurance for further review and recommendations that may include further education, disciplinary action, etc... The Director of Quality Assurance is responsible for this plan of correction.	4/11/09 4/29/09 4/23/09 4/29/09 5/11/09 5/11/09 7/11/09
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cheryl Kudell</i>		TITLE Administrator		(X6) DATE 5/11/09

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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 223 Continued From page 1  
and yell vulgarities ...[Resident] hit her [staff] lower back with the cane." Resident #2's cane was not removed after these incidents, and there was no direction provided by the care plan around the use of the cane as a weapon or monitoring requirements after the 4/9/09 resident to resident altercation.

F 280 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS  
SS=D

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.

This REQUIREMENT is not met as evidenced by:  
Based on interview and record review, staff failed to revise the care plan for 1 applicable resident to reflect a change in behavioral issues (Resident #2). Findings include:

F 223

F 280

F280  
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:

Resident #2's plan of care was reviewed and the comprehensive care plan revised to capture the resident's current behavioral issues.

All residents with behavioral issues have the potential to be affected by this same practice.

The following systemic changes have been made to ensure that the identified practice does not recur. All residents with behavioral symptoms were reviewed and if indicated, their care plan revised. Clinical staff was re-educated and directed to assess residents' behaviors and develop appropriate care plans to address potential and actual behavioral issues.

The Director of Quality Assurance will audit weekly, for 60 days, the shift-to-shift report against comprehensive care plans to ensure the effective implementation of this plan of correction. Identified non-compliance will be immediately rectified. Audit results will be reviewed by the Administrator or designee and trends identified. The outcomes and trends will be reported to the quality assurance committee by the Director of Quality Assurance for further review and recommendations that may include further education, disciplinary action, etc...  
The Director of Quality Assurance is responsible for this plan of correction.

P.O.C. Accepted 5/14/09 Pamela McArthur

4/23/09  
4/29/09

5/11/09  
5/11/09

7/11/09

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F 280	<p>Continued From page 2</p> <p>reflect a change in behavioral issues (Resident #2). Findings include:</p> <p>Per record review, Resident #2 demonstrated aggressive behavior and assaulted another resident on 4/9/09, throwing an object and striking that resident in the head. On 4/11/09, Resident #2 again demonstrated aggressive behavior, assaulting and injuring Resident #1 with his/her cane. After the first incident on 4/9/09, the care plan was not revised to reflect current behaviors and there was no direction provided by the care plan around monitoring requirements after the 4/9/09 resident to resident altercation. The DNS confirmed the above information on 4/20/09 at 2:30 PM.</p>	F 280		
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