AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

November 16, 2023

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 recertification survey conducted on **October 25, 2023.** 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

Pamela M. Cota, RN
Licensing Chief

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475032	A. BUILDING ______ B. WING ______	C 10/25/2023

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

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E 000	Initial Comments An unannounced on-site re-certification survey was conducted at the Vermont Veterans Home by the Division of Licensing and Protection on 10/23-10/25/23 including Emergency Preparedness Requirements for 42 CFR Part 483 requirements for Long Term Care Facilities. The result of the Emergency Preparedness Survey identified no regulatory violations.	E 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. F550 Resident #18 was interviewed by the facility's behavioral health staff regarding this incident. Resident's description of the staff involved in this incident does not reflect anyone who cared for him/her on the day in question. Resident # 18 has had no ill effects from this alleged incident. The facility's HR department conducted an employee investigation and could not substantiate the concerns originally voiced by Resident # 18 Staff education on Professionalism regarding answering call lights, anticipating Resident needs, and customer service began on November 20, 2023, and remains on going. The Director of Nursing Services or designee will conduct four (3) random audits, weekly x 4 weeks, twice a month X 2 months and monthly x 3 months on each neighborhood to ensure staff are maintaining professionalism during their interactions with residents.	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and complaint investigation, including report # 22359 from 10/23/23 through 10/25/23 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: DocuSigned by: Melissa Jackson (7EA4D55658D145F...)
TITLE: CEO
(X6) DATE: 11/15/2023

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 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that staff treated each resident with respect and dignity for 1 of 26 sampled residents (Resident #18) by making remarks related to call bell usage. Findings include: Resident #18 was admitted to the facility in August 2023, and prior to admission Resident #18 had suffered a cerebral vascular accident (a blockage or rupture of an artery to the brain blocking the blood flow to the brain) resulting in right-sided hemiplegia (paralysis of the right arm and leg), and right-hand contracture (shortening and stiffening of the joints preventing normal	F 550	Weekly x 4 weeks, twice a month X 2 months and monthly x 3 months. Audit results will be reviewed at every other month QAPI meeting x 6 months and will continue until the committee determines sustained compliance. Compliance Date: December 9, 2023 **Tag F 550 POC accepted on 11/16/23 by T. Dougherty/P. Cota**	

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F 550	Continued From page 2	F 550		

movement).
On October 23, 2023, when Resident #18 was asked if s/he felt they were treated with dignity and respect s/he stated "Not when someone comes in and says you rang your bell twice in the same hour and the other guy did too. We're not going to spend the whole night coming down here." Resident #18 became visibly upset with a furrowed brow and raised tone as s/he described needing assistance due to their inability to walk and having one hand with very limited use which s/he demonstrated for the surveyor. Resident #18 could not recall what assistance they had rang the call bell for or if they had received the assistance. Resident #18 has a BIMS (Brief Interview for Mental Status) score of 15 indicating intact cognition and was able to identify the time of this interaction as the night before at approximately midnight.

A review of Resident #18's care plan contained focus areas mentioning reliance on call bell use including:
1. Activities of daily living deficit for which interventions included- "Encourage to use call bell for assist. Extensive assist for dressing, Set up assist for eating, Stand lift with 2 assist for toilet and transfer. [name removed] requires limited assistance by 1 staff to turn and reposition in bed as necessary."
2. "[Name removed] is (at) risk for serious injury from falls related to hemiplegia, bladder and bowel incontinence, psychoactive drug use, impaired mobility. Be sure [name removed] call light is within reach and encourage him/her to use it for assistance as needed. [name removed] needs prompt response to all requests for assistance."

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F 550	Continued From page 3 On 10/24/23 at 1 p.m., the unit manager was interviewed regarding the allegation of the disrespectful response reported by Resident #18. To determine the identity of the staff working at the time of the alleged incident the nursing supervisor joined the discussion and provided a paper copy of the schedule in question. When the staff members were identified the surveyor asked if, based on the staff present at the time of the allegation they would be surprised by the report of this disrespectful interaction. Per both the unit manager and the supervisor it would not be surprising if any of the four staff on duty at the time had "used a tone or made brash statements." On 10/25/23 at approximately 2 p.m., the facility administrator provided a copy of the interview conducted by social services with Resident #18 earlier that day. Statements in this interview include- "When asked about how he feels his nursing care is going, [name removed] stated that "everyone is good and helpful. One person is impossible, I don't speak with her". "[Name removed] then stated about 4 days ago at 6 a.m., s/he rang his/her bell to have his/her urine collection device emptied. [name removed] said s/he had to ring a few minutes later because s/he wanted a washcloth for his/her eye. S/he said that a staff member came back to his/her room and said, "We have been in here for five calls in five minutes and something about getting out the door. [name removed] reports s/he told him/her to 'get the hell out of my room now".	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer	F 554		

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F 554	Continued From page 4 medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that a resident who was capable of self-administration of medications was able to store them safely and securely. Findings include: During an interview with Resident #50 on 10/23/23 at 3:12PM it was noted that there were several bottles of dietary and herbal supplements on their overbed table, dresser, shelf, and in a three-drawer plastic bin. These supplements included Chewable Vitamin C, Inflama-Rest (support for healthy inflammation response), RejuvenZyme (heart, joint, and immune support), Magnesium Serene, Wellness Formula, Ashwagandha (rejuvenating tonifier), Tums, and Ultra-Cal Night, Daily essential Enzymes. Per record review Resident #50 has been assessed as capable for self-administration of these supplements. A physician's order states that the resident "may self-administer [his/her] supplements based on [his/her] last self-administration assessment." Review of the facility policy titled Veteran/Member Supplement Use states, "5) The Veteran, Member, responsible party and VVH staff will follow the facility's self-administration of medication policy." The policy titled Medication Administration, Self Storage 1. Any Veteran/Member deemed able to self administer medications may choose to have his/her medications stored in the medication cart	F 554	F554 Resident #50 was provided with a secure cabinet to lock all self-administered medications. All other residents who have self-administered medications have a secure cabinet to store their self-administered medications. All other residents were in compliance. Staff education on monitoring for safety concerns when in a resident's room. This includes but is not limited to, medications, supplements, alcohol, and smoking materials in plain sight. Education began on November 20, 2023, and is ongoing. The Director of Nursing Services or designee will conduct random room safety audits, weekly x 4 weeks, twice a month X 2 months and monthly x 3 months. Audit results will be reviewed at every other month QAPI meeting x 6 months and will continue until the committee determines sustained compliance. Compliance Date: December 9, 2023 **Tag F 554 POC accepted on 11/16/23 by T. Dougherty/P. Cota**	

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F 554	Continued From page 5 room on the unit or in their room. 2. If a Veteran/Member stores medication in his/her room the following must be implemented: A. The medications will remain in a locked container at all times i.e., a locked box. During an interview on 10/25/23 at 11:49 AM the administrator confirmed that the supplement policy does refer to the Medication Administration, Self-policy and that the supplements should be kept secure.	F 554		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656	F656 Resident #18's care plan was updated to reflect his/her pacemaker information. All other residents with pacemakers had their care plan reviewed and all had the appropriate documentation. Education/competencies for all RNs/LPNs on how to update a care plan began on November 20, 2023, and is ongoing. The Director of Nursing or designee will conduct random competency audits weekly x 4 weeks, every 2 weeks x 2 and monthly x 4 monthly to ensure all RNs/LPNs can update care plans appropriately. Audit results will be reviewed at every other month QAPI meeting x 6 months and will continue until the committee determines sustained compliance. Compliance Date: December 9, 2023 **Tag F 656 POC accepted on 11/16/23 by T. Dougherty/P. Cota**	

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F 656	Continued From page 6	F 656		

findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to ensure that each resident has a person-centered comprehensive care plan developed and implemented to address the resident's medical needs for 1 of 26 residents sampled (Resident #18) regarding impaired cardiac output.

Findings include:
Resident #18 was admitted to the facility in August 2023, prior to admission Resident #18 had suffered a cerebral vascular accident (a blockage or rupture of an artery to the brain blocking the blood flow to the brain) resulting in right-sided hemiplegia (paralysis of the right arm and leg), and right-hand contracture (shortening and stiffening of the joints preventing normal

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F 656	Continued From page 7 movement). Additional diagnoses include permanent atrial fibrillation (an abnormal heart rhythm characterized by rapid and irregular beating of the heart) and unspecified bradycardia (an abnormally slow resting heart rate). Per record review on 8/31/23 Resident #18 was sent emergently to the hospital with symptomatic bradycardia and long pauses (abnormally long intervals between heartbeats), "s/he was sent to Albany Medical Center to be evaluated for a pacemaker and per the provider note "it is not completely {clear} why s/he did not receive a pacemaker in Albany Medical Center." The resident returned to the facility from Albany Medical Center on 9/7/23. On 10/10/23 Resident #15 became dyspneic (short of breath), and hypoxic (low oxygen level in the blood), and coughing. Resident #15 was again sent emergently to the local hospital and admitted with congestive heart failure and probable bacterial pneumonia. Resident #15 was admitted to the hospital and on 10/16/23 s/he had a pacemaker placed. A review of the care plan revealed that there was no area relating to the resident's cardiac status nor was there mention of the resident having a pacemaker. During an interview with the unit manager on 10/24/23 at 1:45 p.m. s/he confirmed the care plan did not but should contain reference to the pacemaker and of the the impaired cardiac status of the resident.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		

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F 657	Continued From page 8 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based upon interview and record review the facility failed to ensure the plan of care for 1 resident [Res.#83] of 20 sampled residents with falls was reviewed and revised to prevent future falls and injury. Findings include: Review of Res. #83's medical record reveals the resident was admitted to the facility with diagnoses that included Degenerative Arthritis with severe chronic pain. Per review of Res. #83's Care Plan, the resident is identified as " at risk for fall related injury related to deconditioning, symptoms of pain from	F 657	F657 Resident # 83's care plan was updated to reflect appropriate interventions for the falls identified. Residents experiencing falls will have their care plans reviewed at the facility's weekly falls review meetings. Education/competencies for all RNs/LPNs on how to update a care plan began on November 20, 2023, and is ongoing. The Director of Nursing or designee will conduct random competency audits weekly x 4 weeks, every 2 weeks x 2 and monthly x 4 monthly to ensure all RNs/LPNs can update care plans appropriately. Audit results will be reviewed at every other month QAPI meeting x 6 months and will continue until the committee determines sustained compliance. Compliance Date: December 9, 2023 **Tag F 657 POC accepted on 11/16/23 by T. Dougherty/P. Cota**	

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arthritis, reports history of fall prior to admission" along with "sustained a witnessed fall with no injury, related to Poor Balance, Unsteady gait".
Review of Res.#83's medical record reveals the resident suffered 4 falls between August and September 2023. Progress notes record:
- 8/16/2023 Incident Note. "Resident was calling for help, when LNA [Licensed Nurse's Aide] went to room, [Res.#83] was sitting on the floor in front of [their] recliner. [They] stated [they] slid off recliner ... Neurological checks and vital signs initiated per fall protocol".
- 8/19/23 "Called to the unit by nursing staff to eval [Res.#83] who had rang [their] bell and was noted lying on the floor when staff entered."
- 9/7/2023 [Res.#83] left the dining room (in electric wheelchair) after eating [their] breakfast. Was self-transferring and lost [their] balance. [Res.#83] was noted on the floor with a head wound. [Res.#83] was assisted (via Hoyer lift) off the floor to [their] recliner. Due to the head wound and feeling "oozy" [Res.#83] was transported to Southwestern Vermont Medical Center".
A re-admission update when Res.#83 returned to the Veteran's Home reveals "[Res.#83] was sent from Southwestern Vermont Medical Center [SVMC] to Albany Medical Center after a fall. [They] had a 12 hour stay in the local Emergency Department. [They were] sent to Albany Medical Center from SVMC where [they were] diagnosed with a subdural hemorrhage ...",
[A subdural hemorrhage is a kind of intracranial hemorrhage, which is the bleeding in the area between the brain and the skull. Specifically, it is a bleed just under the dura, which is one of the protective layers of tissue that surrounds the brain].
(www.rwjbh.org/treatmentcare/neuroscience/neurology/conditions/subdural-hemorrhage)

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Further review of Progress Notes for Res.#83 reveals 2 days after the fall with injury on 9/7/23, the resident fell again.
- 9/9/2023 Incident Note: "Resident noted on the floor by rest room door. Pillow placed under resident's head. Per LNA resident was being assisted out of restroom, in which resident started sliding to the floor. LNA in turn assisted resident to floor landing resident on [their] buttocks. Did not hit head ...Resident voiced pain of 7/10 pain to [their] buttock."

Per review of the 'Vermont Veteran's Home Falls Program' [dated March 19, 2014], the policy states "All Veteran/members experiencing a fall will receive appropriate care and investigation of the cause. Assess Veteran/member's condition immediately to determine extent of injury for both witnessed and unwitnessed falls." The Falls policy also includes the statement "Update care plan with new interventions and communicate interventions to staff."

After the fall on 9/9/23, Res.#83's Care Plan was revised with the interventions:
- "Continue interventions on the at-risk plan", dated 9/9/2023 [after the 4th documented fall] along with 'new' interventions listed as monitoring the resident for 72 hours and determining factors contributing to the fall, which according to the 'Vermont Veteran's Home Falls Program' are applied to all residents after all falls.
Further review of Care Plan revisions related to fall risk and actual falls for Res.#83 include the interventions: "Implemented bariatric non-skid socks": listed as a new revision and dated 9/9/2023 but repeating the intervention "Ensure that [Res.#83] is wearing ... h/her anti-skid socks"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475032	A. BUILDING ______ B. WING ______	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERMONT VETERANS' HOME	**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 657	Continued From page 11 dated 4/11/2023. Per record review, after assessing the resident as "able to ambulate with rolling walker unsupervised" and noting that the resident asks for help despite not needing it, after 3 falls, an intervention to prevent future falls was added as "Remind [Res.#83] to call for assistance if walker/wheelchair is not in [h/her] reach before transferring" dated 9/7/23, and then repeated as a new intervention and revision after another fall as "Educated resident use of walker", dated 9/9/23. An interview and record review were conducted with Res. #83's Unit Manager on 10/25/23 at 9:50 AM. The Unit Manager confirmed that new interventions to prevent future falls were not added after a fall on 9/7/23 which resulted in a subdural hemorrhage. The resident suffered another fall on 9/9/23 shortly after returning to the facility, again with no new interventions added to prevent future falls. The Unit Manager also reported that if any interventions were attempted but not put in Res.#83's care plan, there was no process in place to communicate those changes to staff on a continuing basis. Additionally, the Unit Manager confirmed that Care Plan interventions dated as added after falls on 9/7/23 and 9/9/23 were not new interventions or revisions, but identical interventions attempted before that did not prevent future falls, and/or repeating the facility's Falls Policy which is in effect for all residents at all times.	F 657		