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

January 4, 2024

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 complaint investigation conducted on **December 5, 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 12/05/2023

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 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced investigation of 5 facility reported incidents #22404, #22441, #22511, 22483, and #22494 on 11/21 - 12/5/23 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiency was identified:	F 000	Filing of this Plan of Correction does not constitute any admission as to the alleged violation set forth in the Statement of Deficiency. This Plan of Correction is being filed as evidence of the facility's continued compliance with all applicable laws and regulations.	
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record review, the facility failed to protect the resident's right to be free from physical abuse by a resident for 3 of 6 residents in the sample (Resident #1, #3, and #4). Findings include: 1 . Per record review Resident #1 was admitted to the facility on 6/22/23 with the diagnosis of Alzheimer's Disease. Review of Resident #1's	F 600	Resident[s] affected: 1. Resident #1 was discussed during behavior Huddle and his Plan of care for the potential to harm others or to be Harm by others was reviewed and revised. At present he remains on a buddy while awake and 15-minute checks when in bed. Resident #1 was also moved to a private room. 2. Resident #4 was discussed at behavior Huddle and his care plans were review and revised for the potential to be harm by others and a "Stop" sign has been added to his door to his private room. 3. Resident #3 was discussed during behaviors Huddle and his plan of care for behaviors and the potential to harm others was reviewed and revised.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: DocuSigned by: Melissa Jackson
TITLE: CEO
(X6) DATE: 12/28/2023

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 600

Continued From page 1

progress notes and care plan reveal that Resident #1 has exhibited aggression toward staff and other residents, such as yelling, slapping, throwing dishes, grabbing, and being combative with care.

Review of Resident #2's record reveals that s/he was admitted to the facility on 2/22/23 with the diagnosis of Alzheimer's Disease and resides on the facility's licensed memory care unit. Resident #2's progress notes and care plan reveal that Resident #2 can be territorial with his/her perceived space and can exhibit aggression towards others.

On 10/26/2023 at 8:30 PM Resident #1 was found by staff in Resident #2's room on the floor on top of Resident #2. Resident #2 sustained injuries from the incident and was sent to the hospital emergency department (ED) for evaluation and treatment. While in the ED Resident #2 required the administration of IM (intramuscular) Haldol (an antipsychotic medication) for agitation.

Per a progress note written in Resident #1's record, on 10/26/23 at 8:30 PM Resident #1 was found in Resident #2's room, on top of Resident #2 swinging his/her hands and arms toward Resident #2. Resident #1 was separated from Resident #2 and was escorted to their room where s/he got in bed and went to sleep.

Progress notes written in Resident #2's record on 10/26/23 and 10/27/23 reflect that Resident #2 was on the floor with Resident #1 on top of him/her on 10/26. Resident #1 was removed, and Resident #2 was assessed by charge registered nurse (RN). "Resident #2 has multiple abrasions

F 600

Resident(s) who have the potential to be affected:

1. A house audit will be completed on behaviors for any veteran [resident] found to have the potential/actual behavior to harm others will have their care plan[s] reviewed and updated as needed

2. The Director of Behavioral Health along with the nursing staff will provide re-education to the nursing staff on dealing with behavioral veterans [residents], they will focus on resident body language and dealing with Dementia residents who have either actual/potential to be harm or harm others

Systemic Changes:

1. Each unit will have a communication binder for the nursing staff to review each time they arrive for work. In the binder veterans [residents] behavior interventions will be added to the binder to ensure that staff who are reviewing the binder are aware of any behavior changes/interventions.

2. The SDC/Nursing Management will educated the staff on the communication binders' purpose and what their responsibility will be to ensure they have reviewed the binder each time they arrive at work

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F 600	Continued From page 2 and open areas on body including shoulder, arms, back, and right leg." S/he was unable to clearly give an account of what happened. Resident #2 was sent to the hospital by rescue squad. An Incident Note written on 10/26/23 states "Staff noted [Resident #2] was on the floor in [her/his] room while another veteran was swinging [her/his] hands and arms at [them]. Veterans were separated by staff and were assessed for pain and injury. Small scratches, some bleeding noted to right upper thigh, left shoulder, left back of arms and chest. Abrasions noted to right should blade and left tricep. Large skin tear noted to right elbow with moderate bleeding noted. Subcutaneous tissue/?? bone exposed . Areas cleansed and covered. Range of motion intact per norm of veteran. Denies pain." An Acute Visit Provider Note written on 10/27/2023 states that Resident #2 sustained multiple wounds, mostly superficial except for [his/her] right elbow which involved steri strips and bandage. Review of the facility incident file, a witness statement completed by a Licensed Practical Nurse (LPN) who responded to the incident states Resident #2 was "in bedroom and seen on floor in bedroom cradled by another resident, while attempting to defend self. Resident is cornered on the floor, blood is dripping, nurse attempting to break up altercation. Resident has bruising, scratches, and deep laceration on elbow (right)." and "[Resident #1] in another resident's bedroom and seen cradling over another resident. [Resident #1] is punching other resident, while blood is on the floor from other resident. [Resident #1] is separated off top of other veteran, and [s/he] immediately goes in [her/his] room and falls back asleep."	F 600	3. The IDT team will discuss veteran[s]/resident[s] behaviors after morning clinical meeting to ensure behavior interventions have been reviewed and updated timely and if needed the behavior care plan will be revised at morning clinical Quality Assurance: 1. The Director of behaviors and/or designee will randomly audit 10% of the behaviors each month x90-days to ensure timeliness of interventions 2. The Director of Behaviors and/or her designee will report their findings of the audit at the month QAPI 3. The Administrator and Director of Nurses have overall responsibility of this tag. . Education began on 12/28/23 and will continue. Completion date. 01/08/24 **Tag F 600 POC accepted on 1/4/24 by S. Freeman/P. Cota**	

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F 600	Continued From page 3 During a phone interview with the LPN on 12/5/23 at 2:15 PM when s/he responded to the incident s/he saw Resident #1 on-top of Resident #2 and "they were pretty much duking it out, they were punching each other ... and I had to get in and break them apart. [Resident #1] was crouched over [Resident #2] and both were making contact with each other." Prior to the incident Resident #1 had been on 15-minute checks. The LPN also stated that Resident #1 is typically more aggressive and volatile. S/he was placed on the Buddy 1 to 1 staff to resident after the incident. Per interview with the Director of Social Services at 1:30 PM it is likely that Resident #1 had entered Resident #2's bedroom through the adjoining bathroom and woke Resident #2. The Director of Social Services confirmed that the Resident-to-Resident altercation occurred however, due to cognitive issues and the inability for either Resident to recall the event it is undetermined by the facility who the initial aggressor was. 2. Per record review Resident #1 was admitted to the facility on 6/22/23 with the diagnosis of Alzheimer's Disease and resides on the licensed memory care unit. Review of Resident #1's progress notes and care plan reveal that Resident #1 has exhibited aggression toward staff and other residents, such as yelling, slapping, throwing dishes, grabbing, combativeness with care, and recent history of Resident-to-Resident physical abuse. Per record review Resident #4 was admitted to the facility with the diagnosis of Alzheimer's Disease and resides on the licensed memory	F 600		

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F 600	Continued From page 4	F 600		

care unit. On 11/27/23 at 2:45 PM Resident # 4 was the victim of Resident-to-Resident physical abuse when staff witnessed Resident #1 striking him/her twice with a plastic garbage pail. Per a nurses Incident Note written on 11/27/23, when the nurse and licensed nursing assistant (LNA) responded, they saw Resident #4 sitting on the floor against their dresser. The LNA had witnessed Resident #1 striking Resident #4 twice with a plastic garbage pail. Resident #4 had bruising to the area above her/his left elbow, some redness and a scratch to their left side of their back, and a small abrasion across the bridge of his/her nose. Resident #4 denied pain but said that it hurt when s/he was hit.

Per interview with the Director of Social Services on 12/5/23 at 1:30 PM Resident #1 is unpredictable and it is difficult to pinpoint when s/he will become aggressive. The care team has huddles after each incident to review the possible cause of the escalation, and Resident #1 is now on staff 1-1 "Buddy."

3. Per record review, on 11/25/23 Resident #1 was ambulating down the hall on the memory care unit. As s/he was walking by, Resident #3 punched her/him in the left side of her/his face.

Per interview on 12/4/23 at 2:00 PM the LNA who witnessed the altercation confirmed that Resident #3 hit Resident #1. The LNA stated that when Resident #1 was struck s/he stepped back and leaned into the wall with a confused look on her/his face. Resident #1 did not engage in the altercation and the two residents were separated.

During an interview on 12/5/23 at 1:30PM the Director of Social Services confirmed that

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F 600	Continued From page 5 Resident #3 had hit Resident #1 in the face, and that after review of the incident staff were unable to determine why Resident #3 had struck Resident #1. Although Resident #1 seemed to recall the incident for a brief time, there have been no other altercations between the two residents since.	F 600		