VERMONT

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

July 31, 2018

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 **July 11, 2018.** 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

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

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 07/11/2018

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 onsite Emergency Preparedness Review was conducted by the Division of Licensing and Protection during the annual re-certification survey on 7/11/18. There were no concerns related to Emergency Preparedness.	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.	
F 000	INITIAL COMMENTS An unannounced on-site annual re-certification survey was conducted in conjunction with a facility reported incident between 7/8 - 7/11/18. There were regulatory findings surrounding the survey and the facility reported incident.	F 000	**F600 Free from Abuse/Involuntary Seclusion** Resident #97 is at baseline function at this time and has had no declines in status related to this incident. He has no recollection of the incident that occurred on 5/28/18. Social Services has conducted support visits for this resident since the occurrence. He has been social and participating in activities. His care plan has been reviewed and revised to reflect his current status. For all residents admitted, the facility will begin to collect and review any information regarding the resident's social history, behaviors and any pertinent information regarding the reasons for admission. A staff "huddle" will then be conducted and a care plan will be developed to prevent a possible altercation. Staff will be educated to this new process beginning on July 25, 2018 and is on-going. The Director of Social Services or designee will conduct random audits of new admissions to ensure the huddle occurred. The administrator will conduct random audits to ensure compliance. Data from the audits will be brought to the QAPI meeting every other month for six months or until the committee determines resolution.	
F 600 SS=D	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 interview and record review, the facility failed to ensure 1 applicable resident (Resident # 97) was free from physical abuse.	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa A Jaeger BSW, MHA — TITLE: CEO — (X6) DATE: 7/25/18

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 Findings include: Per record review, Resident # 97 was struck twice with a golf club by another resident (Resident # 83) on 5/28/18. Resident # 83 was admitted on 5/23/18 and review of the clinical record indicated that h/she had at least two incidents involving physical violence towards staff and residents prior to 5/28/18. Per staff interview, the golf club was being used therapeutically by another resident that resided in a room adjacent to Resident # 83. Records indicate that Resident # 83 entered this adjacent room, took the golf club and then struck Resident #97 twice on the back of the neck. Resident # 97 did not suffer any injury other than a red mark which may have been there prior to the incident. This is confirmed by written statements from staff who witnessed the incident . On 7/11/18 at 10:45 AM, the facility Chief Executive Officer confirmed that the altercation took place as indicated above.	F 600	The Administrator is ultimately responsible to ensure that Residents are free from abuse. Compliance Date: July 29, 2018. F600 POC accepted 7/30/18 BB,RN|PMC	
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;	F 623	**F623 Notice Requirements Before Transfer/Discharge** The Ombudsman office was contacted on July 24, 2018 to provide all current resident information on Transfer/Discharge status for Resident #57, #115, #114 Any resident who is transferred or discharged from the facility will have the appropriate information forwarded to the office of the Ombudsman in a manner they request, and a copy of the forwarded information will be maintained by the Social Services department. The Director of Social Services or designee will conduct random audits of residents who are transferred or discharged to ensure that the Ombudsman's office was notified. The Assistant Director of Nurses or designee will conduct random audits to ensure compliance. 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 that the Ombudsman's office is notified of resident transfer/discharge. Compliance Date: July 29, 2018. F623 POC accepted 7/30/18 BB,RN|PMC	

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F 623	Continued From page 2 and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how	F 623		

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F 623	Continued From page 3 to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as	F 623		

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F 623	Continued From page 4 well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to notify 3 of 4 applicable residents, Residents # 57, 114 and 115, and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. Findings include: 1. Per record review, Resident # 115 was transferred emergently to an acute care hospital on 4/25/18. There is no indication that the facility provided the transfer notice or notified the Ombudsman as required by regulation. This was confirmed by the facility Chief Executive Officer on 7/11/18 at 109:47 AM. 2. Per record review and staff interview, Resident #114 was transferred from the facility to hospital due to an acute illness on 4/7/18. Interpretive guidance defines temporary transfer for acute illness as a facility initiated transfer which requires written notice to the resident, or the representative, and the ombudsman as soon as practicable. During interview on 7/10/18 at 4:30 PM, the Chief Executive Officer failed to provide evidence that a notice of transfer had been provided to Resident #114, or the representative, or to the ombudsman. 3. Resident #57 was admitted to the facility 11/21/17 and had been transfered/discharged to	F 623		

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F 623	Continued From page 5 the hospital 12/26/17, 1/11/18, 3/15/18, 6/12/18 and 7/3/18 for evaluations and emergent care. The resident has altered mental status and memory loss and per review of the medical record, there was no evidence that a written notice of transfer had been provided to the resident or resident representative. Nor is there indication that notification of the transfer was provided to the Ombudsman. Per interview with the Chief Executive Officer on 7/9/18 approximately at 8:30 AM confirmation was made that the the facility had not been providing notice of transfers to the hospital to the Ombudsman.	F 623	**F645 PASARR Screening** Resident #56, #69, #88, #109 and #111 have had a PASARR screening conducted and forwarded to the appropriate agency, and a copy of the PASARR was placed in the hard copy clinical record. All residents being admitted to the facility will have a PASARR screen conducted prior to/at the admission or as warranted by the Social Worker or designee. Education regarding the PASARR screen was conducted for Admission and Social Services staff on July 24, 2018. The Director of Social Services or designee will conduct random audits of admitted residents to ensure that the PASARR screen was completed. The Administrator or designee will conduct random audits to ensure compliance. 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 that PASARR Screens are conducted for residents on admission. Compliance Date July 29, 2018. F645 POC accepted 7/30/18 BBwRN/PMC	
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph	F 645		

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F 645	Continued From page 6 (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental	F 645		

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F 645	Continued From page 7 disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to assure that residents, with a qualifying mental disorder or intellectual impairment are not admitted to the facility via a Step 1 screening and/or receive appropriate services per a Step 2 screening for 5 of 29 residents reviewed, Residents #56, 69, 88, 109 and 111. Findings include: 1. Per record review Resident #111 was admitted to the facility on 6/11/2018. There is no PASRR (Pre-Admission Screening & Record Review) present in the Electronic Health Record (EHR) or the paper record. In an interview on the afternoon of 7/10/2018 the Director of Social Services confirmed that there was no PASRR screening available for this resident. 2. Per record review Resident #56 was admitted to the facility on 10/29/2014. There is no PASRR present in the EHR or the paper record. In an interview on the afternoon of 7/10/2018 the Director of Social Services confirmed that there was no PASRR screening available for this resident. 3. Per record review Resident #88 was admitted to the facility on 5/11/2018. There is no PASRR present in the EHR or the paper record. In an interview on the afternoon of 7/10/2018 the	F 645		

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F 645	Continued From page 8 Director of Social Services confirmed that there was no PASRR screening available for this resident and that a request had been sent to the hospital for a copy of his/her PASRR. 4. Resident #69 was admitted to the facility 4/7/14 and per record review on 7/10/18 there was no evidence of a PASRR I being completed. Confirmed by Director of social services at 9:26 AM on 7/11/18 that there was no PASRR I for the resident and one was completed by the social worker on 7/10/18 at the facility. 5. There is no evidence in the EHR or paper record that Resident #109 had a PASRR Step I completed prior to admission to the facility. Per interview with the MDS Coordinator on 7/ 10/18 at 12:13 PM, s/he stated that the resident had a primary diagnosis of dementia and did not require a Step II, but wasn't sure how that would be determined without a Step I. The Director of Social Services confirmed on 7/11/18 at 9:26 AM that there was no Step I completed for this resident.	F 645	**F656 Develop/Implement Comprehensive Care Plans** Resident #57 had a care plan developed for the Foley Catheter. Resident #44 had a care plan developed for pain management. All residents who are on an active pain management plan and those who have a Foley Catheter will be reviewed to ensure that a care plan was developed. A care plan will be placed as warranted as a result of the audit. The Clinical Care Coordinators or designee will ensure any resident with a Foley Catheter and on Pain Management will have a care plan developed with any new Foley Catheter or Pain Management or at the time of the MDS assessment. The Assistant Director of Nurses will conduct random audits to ensure compliance to this area. Education on developing a care plan will be provided to nursing staff on July 19, 2018 and will be ongoing. Data from the audits will be brought to the QAPI meeting every other month for six months or until the committee determines resolution. The Director of Nurses is ultimately responsible to ensure that Care plans are developed as warranted. Compliance Date: July 29, 2018. F656 POC accepted 7/30/18 BBortell RN | PMC	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 -	F 656		

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F 656	Continued From page 9 (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 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that a comprehensive care plan was developed for 2 of 29 residents, Resident #44 regarding pain and Resident #57 regarding an indwelling catheter. Findings include:	F 656		

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F 656	Continued From page 10 1. Resident #57 was re-admitted to the facility on 7/6/18 with an indwelling urinary catheter. Per record review and interview with the Registered Nurse (RN) unit manager on 7/11/18, the resident did not have a catheter when s/he was transferred to the hospital on 7/3/18. The RN further stated that the catheter was to remain in place secondary to Benign Prostatic Hypertrophy and Chronic Kidney Failure. There is no evidence that the facility developed a comprehensive care plan or address that the resident has an indwelling urinary catheter that requires care. The RN confirmed at 12:20 PM on 7/11/18 that a care plan had not been developed to include an indwelling catheter and stated that there should be one to reflect the current status of this resident. 2. Per record review Resident #44 was admitted to the facility on 4/25/18 and has the following diagnoses: low back pain and chronic pain syndrome. Per review of a physician's progress note from 7/2/18, the resident's "pain is worse in thigh, almost fell walking. Pain and swelling very localized to lateral thigh". Per review of the nursing progress note from 7/10/18, "Oxycodone (medication used for pain) 5 milligrams (mg) by mouth was administered for right thigh pain 10/10. Pain reassessed 8/10. Member is scheduled for right thigh ultrasound. S/he is in no distress, no grimacing, in good spirits, maintaining usual routine". Upon further review, there was no evidence in the medical record that a care plan was developed to monitor and manage the resident's pain. Per interview on 7/11/18 at 9:33 AM, the Unit Manager confirmed that there was no care plan developed to monitor and manage Resident #44's pain.	F 656		

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	475032	A. BUILDING _____ B. WING _____	C 07/11/2018

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 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to label drugs and biological's in accordance with accepted professional principles for 1 of 4 medication carts. Findings include: Per observation on 7/10/18 at 12:13 PM of a medication cart on the American Way Unit, a bottle of Lantus 100 insulin (medication used to	F 761	**F761 Label/Storage Drugs and Biologicals** All insulin vials were audited to ensure that if they are opened that the date was placed on the vial for the date the vial is to be discarded. all medication rooms were audited, and all expired and discontinued medications were destroyed per facility protocol. The facility will continue to remove medications from service that are discontinued or expired and place them in the appropriately marked container in the locked medication room for return or destruction. The Clinical Care Coordinator or designee will conduct weekly random audits of the medication rooms and medication carts to ensure insulin vials are dated when opened and expired or discontinued medications are destroyed per policy. The Director of Nurses or designee will randomly conduct audits in these areas to ensure compliance. Nursing staff will begin to be educated on dating all insulin vials when opened and to ensure expired and discontinued medications are destroyed or returned as directed July 18, 2018 and will be ongoing. Data from the audit will be brought to the QAPI meeting every other month for six months or until the committee determines resolution. The Director of Nursing is ultimately responsible to ensure that medications are properly stored and destroyed.	

Compliance Date: July 29, 2018.

F761 POC accepted 7/30/18 BBartell RN/PSNE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 761	Continued From page 12 lower blood sugar) was labeled with a date of 6/4/18. Per interview with a Registered Nurse (RN) at that time, s/he confirmed that the bottle of insulin was currently being used for Resident #44; that the insulin bottle was outdated, and should only be used for 28 days once opened. Upon further observation of the same medication cart, a second bottle of Lantus 100 unit/ml insulin for Resident #92 was not labeled with date opened. Per interview with the RN at that time, s/he confirmed that the bottle of insulin was not labeled with date opened and was currently being used for Resident# 92. Per review of the facility policy (Storage and Expiration of Medications, Biological's, Syringes and Needles) section 5.0 read, "Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."	F 761		