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

August 23, 2019

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 investigation conducted on **August 6, 2019.** 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

| 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 08/06/2019 |

| 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<br><br>An unannounced on on-site investigation of seven entity reported incidents were investigated by the Division of Licensing and Protection between 8/5 and 8/6/19. There was a regulatory finding surrounding the allegations of resident to resident abuse. | 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 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interview and record review, the facility failed to ensure that one of five residents in the applicable sample, Resident #1 was free from physical abuse by another resident. Findings include:<br><br>Resident # 1 was punched in the mouth by another male resident [Resident #2] on 7/23/19, while seated at a dining room table during breakfast. Resident #1 and the chair that s/he was sitting in was pushed over onto the floor by | F 600 | **F600 Free from Abuse/Involuntary Seclusion**<br><br>**Resident #2 is at baseline function at this time with no recollection of the incident that occurred on 7/23/19. The investigation revealed that this resident likely acted out as a misunderstanding at breakfast due to abrupt scheduling changes with this resident's dining location and not eating a meal with their spouse. Social Services has conducted support visits for this resident since the occurrence as well as being evaluated by psych services. This resident has been social and participating in activities with no further behaviors noted. This resident was initially placed on 1:1 monitoring and has since been revised to have 15- minute checks.**<br><br>**Resident #1 has no noted negative effects from the altercation. This resident continues to be social and active in the facility. The care plan was reviewed and revised to monitor for latent injury, no injury is noted. This resident voice's they feel safe in the facility.**<br><br>**The facility has changed its policy to ensure that dining room schedules are not altered without advanced notice. In the event that the dining room schedules need to be changed nursing staff will be notified so that resident's preferences with table mates can be maintained.** | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Melissa A Jackson, MNHA, FACHCA | CEO | 8/14/19 |

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<br>Resident #2 who continued to make verbal threats and attempt to physically assault him/her. Per interview with the Licensed Nursing Assistant that witnessed the incident, s/he heard Resident #2 yelling and hollering and turned to see him/her punch Resident #1 in the mouth and then push the chair over causing Resident #1 to fall to the floor. Resident #1 sustained minor injuries to his/her lips. Staff had to intervene to prevent further assault to Resident #1 by Resident #2. Per interviews with a third resident that was present and witnessed the incident, Resident #2 thought the eggs and bacon that had been given to Resident #1 was his/hers and Resident #1 told Resident #2 to go ahead and take them and s/he further stated that is when Resident #2 hit Resident #1. Review of the medical records provides evidence that Resident #2 had a diagnosis of dementia with behavior disturbances and had agitated outbursts toward the staff on numerous occasions the three weeks prior to the incident. The Registered Nurse Unit Manager confirmed, on 8/6/19 at 10:40 AM that this resident to residednt incident occured. | F 600 | **In the event that a dining room schedule changes and residents must eat in a different location, the Supervisor or designee will monitor the residents in the alternate dining location to provide extra assistance and ensure resident satisfaction with their seating at the meal.**<br><br>**Staff have begun to have education on August 14, 2019 for the need to ensure residents are seated at preferred tables with preferred tablemates and in the event the dining room schedules need to be changed residents will continue to be seated with preferred tablemates.**<br><br>**The Assistant Director of Nurses or designee will conduct random audits of resident seating satisfaction with any alternate dining location.**<br><br>**The Assistant Administrator or designee will conduct random audits to ensure compliance in this area.**<br><br>**Data from the audits will be brought to the QAPI meeting every other month for six months or until the committee determines resolution.**<br><br>**The Administrator is ultimately responsible to ensure that Residents are free from abuse.**<br><br>**Compliance Date: August 21, 2019**<br><br>F600 POC accepted SFreman RN/PMC 8/21/19 | |