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 19, 2021

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 and complaint investigation completed on **October 20, 2021.** 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

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 10/20/2021

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 Emergency Preparedness (EP) review was conducted in conjunction with the annual recertification survey, by the Division of Licensing and Protection from 10/18/21 through 10/20/21. There were no EP regulatory violations identified.	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 and investigations of 4 complaints was conducted by the Division of Licensing and Protection from 10/18/21 through 10/20/21. The facility was found to have the following regulatory deficiencies:	F 000	**F554 Self-Admin Meds-Clinically Appropriate** **Resident #34 has a Medication Self-Administration Safety Screen completed on 10/21/21. All resident currently taking supplements have had appropriate physician orders written and a Medication Self Administration Safety Screen completed.**	
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 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, staff interview, and record review, the facility failed to determine whether it is clinically appropriate for residents to self-administer medications for one of 21 residents (Resident #34). Findings include: 1. Per observation on 10/20/21 at approximately 09:00 AM, Resident #34 was observed with a variety of supplement containers in their room. Per record review, Resident #34 has diagnoses of Parkinson's Disease, depressive disorder, anxiety disorder, visual hallucinations, and Vitamin D deficiency. A Provider note from 8/9/21	F 554	**The facility has discontinued use of the Resident Supplement Use Release form and has updated medication administration policies to include supplements. Education on this policy change began on November 10, 2021, and will continue until all members of staff are educated.** **The Director of Nursing or designee will conduct random audits to ensure that Medication Self Administration Screens are completed per facility policy.** **Data from the audits will be brought to the QAPI meeting every other month for six months or until the committee determines resolution.** **Compliance Date: November 12, 2021**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa A Jackson MBA, FACHCA | TITLE: CEC | (X6) DATE: 11/12/2021

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 554	Continued From page 1 at 12:22 PM states, "On evaluation of [Resident #34's] new vitamins, it was noted that [they] had taken 22 5,000 IU chewable vitamin D gummies in the past 4 days ... check vitamin D level and kidney function." A nursing note from 8/9/21 at 12:30 PM states, "[Resident #34] pulled the fire alarm this morning on the unit ... [They] stated to me that [they] 'have a bomb in [their] stomach that is going to explode' and that is why [they] pulled the fire alarm. I asked how the bomb got into [their] stomach and [they] pointed to some vitamin chews ... [Resident #34] received a bag of 30 Vitamin D chews ... last week on Friday; today there are 8 Vitamin D's left ... Provider advised [Resident #34] that taking that much Vitamin D is not good for [them] and that we need to look into this more ... I asked [Resident #34] if I could take the bag of vitamins out to the provider and [they] handed them to me but then grabbed them back and attempted to take more out to eat." On 8/10/21 a provider order was placed for a "vitamin D level" lab test. On 8/17/21 a provider order was placed for "cholecalciferol (Vitamin D) tablet 1,000 UNIT - give 2 tablet by mouth one time a day for Vitamin D deficiency." The resident suffered no harm from this overdose. Per record review, there is no current or past order for the 5,000 IU Vitamin D chews. The only order mentioning supplement self-administration is an order placed on 7/20/21 that states, "veteran my keep the following supplements per [their] request, in [their] room: , SuperGrapes chews, SuperBeets, SuperBeets Collagen, Turmeric-Curcumin, Active B-Complex, Neo40" but does not mention Vitamin D chews. There is no evidence in the medical record that Resident #34 was assessed for competency and safety in being able to self-administer Vitamin D or other	F 554	**TAG F 554 POC Accepted on 11/19/21 G. Mercure/P. Cota**	

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F 554	Continued From page 2 medications/supplements prior to the overdose or following the overdose. Review of the facility's policy "self-administration of medications" states that "those who desire to self-administer medications are permitted to do so if the facility's Interdisciplinary Team (IDT) has determined that the practice would be safe for the resident and others and there is a prescriber's order to self-administer." The policy also states, "1. An assessment for self-administration of medications will be completed prior to Veteran/Member self-administering medications... C. The Veteran Member is to be assessed quarterly and as needed for safety and compliance utilizing the 'Assessment for Self-Administration of Medications' [form] ... D. transcription of provider's orders and maintenance of an up-to-date MAR (medications administration record) is required." Per review of the facility's "Resident Supplement Use Release", the form states "I will make arrangements to take these medications myself or to arrange for a responsible adult (not an employee of the Vermont Veteran's Home) to administer them to me. I will keep the Vermont Veteran's Home up to date with what supplements I am taking. I will not hold the Vermont Veteran's Home or any of its employees or providers responsible for any adverse effects or drug interactions related to my decision to take supplements." Per record review, Resident #34 signed this release on 8/4/21 but the supplements listed on the form did not include Vitamin D chews. Per interview on 10/20/21 at approximately 9:45 AM, the unit manager stated that the facility does	F 554		

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F 554	Continued From page 3 not consider supplements (such as over-the-counter, non-FDA-approved vitamins) as medications under the policy for self-administration of medications and that "nursing is not responsible" for monitoring them. They did state that following Resident #34's overdose, the team removed the Vitamin D chews from their room and nursing started administering Vitamin D supplements with a provider's order. The unit manager stated that self-administered supplements should be ok'd by the provider for the resident to take and that the team should assess the resident for their ability to safely administer supplements to themselves. The unit manager confirmed that vitamin D has the potential to cause harmful side effects in excess and that they could find no evidence in the record of an assessment of the resident's competency to self-administer medications, nor an order for the Vitamin D Chews.	F 554	**F600 Freedom from Abuse, Neglect, and Exploitation** **Resident #70 remains at base line and has no negative outcomes form this event.** **Facility staff was reeducated on our abuse prevention policy beginning on August 18, 2021** **Nursing staff were educated on their role in reviewing the written witness statements obtained during an investigation so to immediately identify potential abuse, neglect or exploitation beginning on 8/18/2021. This information was provided to the Survey Team during their recertification visit.** **The Administrator has been conducting weekly random audits of accident and incident investigations to determine if witness statements contain potential abuse, neglect, or exploitation since 8/23/2021 This information was provided to the Survey Team during their recertification visit.** **Data from the audits will be brought to the QAPI meeting every other month for six months or until the committee determines resolution.** **Compliance Date: November 12, 2021**	
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;	F 600	**TAG F 600 POC Accepted on 11/19/21 G. Mercure/P. Cota**	

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F 600	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to protect residents from abuse for 1 applicable resident, (Resident #70). Findings include: Per review of Resident #70 medical record revealed s/he was admitted on 9/1/2020 and requires supervision for ADL's (Activities of Daily Living), is independent with ambulation on the unit and is on the Buddy System (1:1) for behaviors and elopement risk. On 8/15/21 an "INCIDENT & ACCIDENT CHECKLIST " was completed by the Supervisor/Charge nurse, and included a brief statement that stated, "naked, swinging at Buddy + staff. Punched staff. Put on clothes, went to B wing smoking area. Smoking, calmer, refused to go to ED (Emergency Department)." Actions listed on this form were: Notification to Provider, Family, Nursing Supervisor, Charge nurse, Admin on call, Police, and EMS (Emergency Medical System). In addition, staff statements were collected and attached to the INCIDENT & ACCIDENT CHECKLIST form. Several statements were obtained and consistent with the events of this incident. Additional comments were provided by the LNA who appeared to have taken the lead on this incident and s/he documents the following: "We tried to redirect, ask questions, [pronoun omitted] continued to throw hits at us. Even when [pronoun omitted] tried to get in peoples cars we kept our distance but he still charged at us for following. Once [pronoun omitted] started to charge towards the other LNA, I put [pronoun omitted] in a headlock." On 8/17/21 at approximately 1400 a Supervisor/	F 600		

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Charge Nurse completed an INCIDENT & ACCIDENT CHECKLIST, including a brief statement of what happened, and is as follows: "While investigating incident from Sunday 8/15: [sic] it was noted that staff member stated, "I followed and the [sic] put [pronoun omitted] in a headlock & lowered [pronoun omitted] to the ground." The Supervisor/Charge Nurse documented, "This staff member has been sent home & contract ended. Police called, waiting for call back. POA (Power of Attorney) notified." This staff member completed an additional statement that stated, " This nurse was alerted to an issue that occurred over the weekend. A body audit was completed on the Vet. [pronoun omitted] does have bruising to the left upper inside of arm near armpit. [pronoun omitted] also has two bruises on left forearm. There is an area that is rash like on the front of [pronoun omitted] throat that was appx (approximately) 2 cm (centimeters) by 1 cm. The rest of [pronoun omitted] skin was clear and injury free. Photos were taken. Vet did state to this nurse that a staff member had "grabbed me from behind and put me on the ground." [pronoun omitted] did say that he was "not hurting anywhere" and that [pronoun omitted] "was alright". Vet was pleasant and cooperative with this nurse. Vets POA/sister [proper name omitted] was called and notified of what was going on and that actions were being taken to remedy the situation. She was understanding and pleased that the facility "is on top of the situation". DON (Director of Nursing) advised of the information."

Interview on 10/19/21 at approximately 12:20 PM with the DON/DNS (Director of Nursing Services), who confirmed the staff member had put the resident in a headlock and taken him/her to the

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F 600	Continued From page 6 ground and this situation was abusive to the resident.	F 600	**F608 Reporting of Reasonable Suspicion of a Crime** Resident #70 remains at base line and has no negative outcomes form this event. All Facility staff was reeducated on our abuse prevention policy including the requirements of timely reporting beginning on 8/18/2021 Nursing staff were educated on their role in reviewing the written witness statements obtained during an investigation so to immediately identify potential abuse, neglect, or exploitation and their responsibly report this information timely. Education began on 8/18/2021. This information was provided to the Survey Team during their recertification visit. The Administrator has been conducting weekly random audits of accident and incident investigations to determine if witness statements contain potential abuse, neglect, or exploitation since 8/23/2021. This information was provided to the Survey Team during their recertification visit. Data from the audits will be brought to the QAPI meeting every other month for six months or until the committee determines resolution. Compliance Date: November 12, 2021	
F 608 SS=D	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to report	F 608		

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F 608	Continued From page 7 suspicion of a crime to the State Agency within the required time frame for 1 of 4 complaints (resident #70). Findings include: Per review of facility investigation on 10/19/21, it was revealed that the allegation of abuse of resident #70 occurred on 8/14/21. A staff member reported to the DNS (Director of Nursing Services) that S/he overheard two LNA's (Licensed Nurses Aides) talking. One LNA said to the other, ".....[pronoun omitted] put [pronoun omitted] in a headlock and took [pronoun omitted] down." A form titled, "INCIDENT & ACCIDENT CHECKLIST" was completed on 8/15/21 by the charge nurse which included a brief statement of what happened. The brief statement stated, "Naked, swing at buddy + staff. Punched staff. Put on clothes, went to B wing smoking area. Smoking, calmer, refused to go to ED (Emergency Department)." Attached to this form were staff statements that were consistent with the brief statement noted above. One statement attached, read in the "Additional comments" section, "We tried to redirect, ask questions, [pronoun omitted] continued to throw hits at us. Even when [pronoun omitted] tried to get in peoples cars we kept our distance but [pronoun omitted] still charged at us for following. Once [pronoun omitted] started to charge towards the other LNA, I put [pronoun omitted] in a headlock." A note dated 8/15/21 at 21:15 by a nurse states, " Resident came out of [pronoun omitted] naked, started punching [pronoun omitted] "buddy" and another LNA. Then ran outside through the end of the hall. Supervisor, provider called. Police was contacted, sister notified. Attempt made to take [pronoun omitted] into ED but resident	F 608	**TAG F 608 POC Accepted on 11/19/21 G. Mercure/P. Cota**	

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F 608	Continued From page 8	F 608		

refused to go. No apparent injuries on a vet or any other people involved. Vet (Veteran) seems to be calming down, verbalizes understanding boundaries at this time." A statement from the nursing supervisor on 8/15/21 at 22:11 states, "At around 2140, [pronoun omitted] came out of room completely undressed, [pronoun omitted] swung at [pronoun omitted] buddy person and another lna, then went into room put on pj bottoms, ran down hall outside B wing smoking allowed area. had police officer [proper name omitted] come in, called rescue squad per admin on call, they came, [proper name omitted] was outside smoking a cigarette and cup of water. [pronoun omitted] was calm, refused to go in ambulance to SVMC ER. they indicate they cannot take [pronoun omitted] against [pronoun omitted] will. [pronoun omitted] told them [pronoun omitted] will remain calm, and not assault anyone else. [pronoun omitted] remains on buddy. per admin on call we need to call police and rescue if [pronoun omitted] becomes further assaultive behaviors and have [pronoun omitted] taken to ER for eval. presently outside smoking with buddy person. no further aggression as of this time." Actions taken were listed as: notification of provider, family, Nursing Supervisor, Charge nurse, Admin on call, Police, and EMS (Emergency Medical Services). As well, any injuries were noted and staff statements were gathered.

A second INCIDENT & ACCIDENT CHECKLIST completed by nurse supervisor dated 8/17/21 at 1400 revealed a brief statement of what happened as, "While investigating incident from Sunday 8/15/: [sic] it was noted that staff member stated "I followed and put [pronoun omitted] in a headlock & lowered [pronoun omitted] to the

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F 608	Continued From page 9 ground." An investigation report was completed by the DNS and forwarded to the Administrator on 8/23/21. The DNS documented that "On August 17, 2021, activity aide reported to DNS [pronoun omitted] overheard two LNAs in conversation stating, "[proper name omitted], [S/he] put [pronoun omitted] in a headlock and took down." DNS spoke with [proper name omitted] LNA [pronoun omitted] verbalized [pronoun omitted] grabbed [pronoun omitted] arms. [Proper name omitted], LNA written statement [pronoun omitted] indicated [pronoun omitted] "I followed and put [pronoun omitted] in a headlock and lowered [pronoun omitted] to the ground." The RN (Registered Nurse) supervisor assessed the resident and noted left axillary bruise and two bruises to the left anterior forearm. Resident verbalized to RN supervisor "grabbed me from behind and put me on the ground." [pronoun omitted] said [pronoun omitted] was "not hurting anywhere" and that [pronoun omitted] "was alright." The facility failed to report this incident to the State Survey Agency within 24 hours of this incident. Interview on 10/19/21 at approximately 12:20 PM with the DNS, confirmed that the incident occurred on 8/15/21 and was not reported to the State Survey Agency until 8/17/21.	F 608		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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F 689	Continued From page 10 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each resident receives adequate supervision to prevent accidents for 5 of 21 residents (Resident #7, #66, #70, #73, and #87) as evidenced by the facility failing to regularly assess for safe smoking competency. Findings include: 1. Per record review, Resident #7 was admitted to the facility on 1/28/16 and was screened for safe smoking upon admission and quarterly thereafter, with the exception of 1 missing quarterly smoking assessment that was due for the month of December 2020. 2. Per record review, Resident #66 was admitted to the facility on 7/20/18 and was screened for safe smoking upon admission and quarterly thereafter, with the exception of 1 missing quarterly smoking assessment that was due for the month of December 2020. 3. Per record review, Resident #70 was admitted to the facility on 9/1/20 and was screened for safe smoking upon admission and quarterly thereafter, with the exception of 1 missing quarterly smoking assessment for the month of December 2020. Per the facility policy and procedure titled "RESIDENT SMOKING - Nursing Home", with a last revision date listed as 10/13/21, under bullet #6 which states, "All Veteran/Members who	F 689	**F689 Free of Accident Hazards/Supervision/Devices** **Residents #7, #66, # 73, and # 87 have had a smoking safety screen completed. A review of all resident smokers was conducted, and any missing smoking safety screens were completed.** **All staff was educated on the facility's smoking policy beginning10/21/2021.** **The Director of Nursing or designee will conduct random audits of all smokers to ensure smoking screen are completed per facility policy.** **Data from the audits will be brought to the QAPI meeting every other month for six months or until the committee determines resolution.** **Compliance Date: November 12, 2021** **TAG F 689 POC Accepted on 11/19/21 G. Mercure/P. Cota**	

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F 689	Continued From page 11 express a desire to smoke will be screened by the Interdisciplinary Team (IDT) on upon [sic] admission/request to smoke and quarterly thereafter.". An Interview with the DON on 10/20/21 at 12:15 PM confirmed that the above listed residents had not received their quarterly safe smoking assessment for the month of December 2020. 4. Per record review, Resident #73 was admitted to the facility on 12/1/20 and was screened for safe smoking on 12/4/20. Per the "Smoking - Safety Screen" assessment from 12/4/20, Resident #37 was observed to have demonstrated an ability to smoke safely without supervision. Resident #73 was screened again for safe smoking with a "smoking - safety screen" assessment on 2/22/21. Resident #73 was assessed to still have the ability to smoke safety without supervision, but was noted to have been found smoking indoors at the exit door of the hallway. As a result, Resident #37's cigarettes and smoking materials were taken from them and stored in the medication storage room. Per the record, there is no evidence of any subsequent safety screens or assessments for smoking to date. Per review of the facility policy "Resident Smoking - Nursing Home" under bullet #6, "all Veterans/Members who express a desire to smoke will be screened by the Interdisciplinary Team (IDT) upon admission/request to smoke and quarterly thereafter." Bullet #8 also reads, "IDT will complete the 'Smoking - Safety Screen' in the Veteran's/Members electronic medical record (EMR) and the results of the screen will be included in the Veterans/Members Care Plan."	F 689		

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F 689	Continued From page 12 Per interview on 10/20/21 at approximately 11:30 AM, the Unit Manager confirmed that Resident #37 had not been assessed for smoking safety since 2/22/21 and that the "Smoking - Safety Screen" is what the facility uses to assess a resident's ability to smoke safety without supervision. 5. Per record review, Resident #87 was admitted to the facility on 6/10/21 and was screened for safe smoking on 6/11/21. Per the "Smoking - Safety Screen" assessment from 6/11/21, Resident #87 was observed to have demonstrated an ability to smoke safely without supervision with no concerns noted. Per the record, there is no evidence of any subsequent safety screens or assessments for smoking to date despite several other quarterly assessments having been completed in late September of 2021. Per review of the facility policy "Resident Smoking - Nursing Home" under bullet #6, "all Veterans/Members who express a desire to smoke will be screened by the Interdisciplinary Team (IDT) upon admission/request to smoke and quarterly thereafter." Bullet #8 also reads, "IDT will complete the 'Smoking - Safety Screen' in the Veteran's/Members electronic medical record (EMR) and the results of the screen will be included in the Veterans/Members Care Plan." Per interview on 10/20/21 at approximately 11:30 AM, the Unit Manager confirmed that Resident #87 had not been assessed for smoking safety during their first quarterly assessments of Resident #87 and that the "Smoking - Safety Screen" is what the facility uses to assess a	F 689		

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F 689	Continued From page 13 resident's ability to smoke safety without supervision.	F 689		
F 730 SS=B	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to complete a performance review of every nurse aide at least once every 12 months. Findings include: 1. Per review of nurse aide education records, two "temporary" nurse aides (nurse aides who are licensed and employed without a permanent schedule, as defined by the Vermont State Employee's Association (VSEA)) who had been employed for over a year at the facility did not have any annual performance reviews in their provided records. Per interview on 10/20/21 at approximately 12:00 PM, the Administrator stated that the facility's nursing workforce is unionized and that the union contract prohibits them from doing performance reviews with any "non-classified" employees (including temporary employees). They also confirmed that no temporary nurse aides in the facility receive annual performance reviews. Per review of the "Performance Management"	F 730	**F730 Nurse Aide Perform Review -12 hr-yr In-Service** **An audit was completed of all full-time and temporary LNA's personnel files to identify those with missing evaluations. All missing evaluations were completed.** **All temporary LNA staff have been added to the annual performance evaluation tracker to ensure timely completion going forward.** **The Chief Operating Officer or designee will conduct monthly audits of LNA performance evaluations to ensure compliance with this standard.** **Data from the audits will be brought to the QAPI meeting every other month for six months or until the committee determines resolution.** **Compliance Date: November 12, 2021** **TAG F 730 POC Accepted on 11/19/21 G. Mercure/P. Cota**	

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F 730	Continued From page 14 policy within the VSEA union contract, the policy states that "all officers and employees of the State who act in a supervisory capacity shall at least annually complete performance evaluations for each classified employee under their immediate supervision." Nowhere in the policy does it state that performance evaluations cannot or should not be completed for non-classified employees.	F 730	**F761 Label/Store Drugs and Biologicals** **All medication rooms, carts, and storage areas have been inspected an all-expired medication and medical supplies have been removed.** **Nursing staff have been educated on ensuring all medications and biologicals are labeled in accordance with professional principles beginning on 11/5/2021** **Weekly audits of medication storage areas will be completed weekly and reviewed by the Director of Nursing Services.** **Data from the audits will be brought to the QAPI meeting every other month for six months or until the committee determines resolution.** **Compliance Date: November 12, 2021**	
F 761 SS=E	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	F 761	**TAG F 761 POC Accepted on 11/19/21 G. Mercure/P. Cota**	

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F 761	Continued From page 15 by: Based on observation and staff interview, the the facility failed to ensure that all drugs and biological's used in the facility are labeled and stored in accordance with professional standards, including expiration dates on 3 of 4 medication storage rooms. Findings include: 1. 3 of 4 observed med rooms had the following expired medications and medical supplies: In the American Way medication storage room, 1. A refrigerated tube of Preparation H 0.25% cream expired 7/21. 2. A tray containing approximately 90 tiger top Vacutainer tubes that expired 9/30/21. These observations were confirmed by the Unit Nurse on 10/19/21 at 3:05 PM. In the Brandon Boulevard medication room, (19) Vacutainers expired 9/30/21 (40) Butterfly needle systems expired 6/30/21 (5) Vacutainers expired 7/31/21 (1) Vacutainer expired 8/31/21 (26) Vacutainers expired 11/1/2019 (4) Monoject Multi-Sample Transfer sets with holders and Safety Needle expired 2/28/21 (49) 3 mg Syringes with 25 gauge x 5/8 hypodermic needles expired 2/2020 (100) 22 gauge x 1 1/2 inch hypodermic needles expired 8/31/21 (13) BBL Culture swabs collection and transport system expired 9/30/21 (6) Albuterol Sulfate inhalation Solutions 0.083%, 2.5 mg/3 mg expired 9/21 (30) Ipratropium Bromide and Albuterol Sulfate Inhalation Solution 0.5 mg/3 mg per 3 ml expired 9/21 (1) Oasis Oral Demulcent Moisturing Mouthspray	F 761		

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F 761	Continued From page 16 expired 9/2021 (1) Bottle of a 1000 tablet, 500 mg Acetaminophen tablets (unopened bottle) expired 8/21 (1) Bottle Acidophilus Probiotic 1 Billion (100 capsules), opened with the following directions: "Directions: Store unopened container at room temperature. REFRIGERATE AFTER OPENING" In the Cardinal Point medication room, 1. 14 BBL Culture swabs (used to obtain wound cultures) expired 9/2018. 2. A large bag of BactiSwabs expired 8/13/2019. These observations were confirmed by the unit manager on 10/19/2021 at 4:15 PM. 2. A Daily Fridge/Freezer Temperature log located on the medication refrigerator in the Cardinal Point medication room states " Fridge Temp 36-40 degrees F. If temperature is out of range, notify maintenance department right away. Put out of order sign on the door. Inspect and remove items if needed." The Daily Fridge/Freezer Temperature log reflects the following temperatures: on 10/1 AM/34 & PM/29, 10/2 AM/29, 10/3 PM/35, 10/4 AM/38 & PM/46, 10/5 PM/34, 10/6 PM/34, 10/8 PM/42, 10/9 PM/44, 10/10 PM/42, 10/11 AM/41& PM/42, 10/14 PM/46, 10/16 AM/42 & PM/44, and 10/18 AM/48 & PM/48 degrees. There were four insulin pens and an "insulin universal kit" being stored in the refrigerator. Per interview with the Licensed Practical Nurse (LPN) on 10/19/2021 at 4:05 PM it is the expectation that the nurse who identifies a temperature outside the range indicated on the log would notify the supervisor.	F 761		

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F 761	Continued From page 17 On 10/19/2021 at 4:15 PM the unit manager confirmed that the above temperatures documented on the log were not in range indicated on the log. On 10/20/2021 at approximately 9:00 AM the unit manager stated that the refrigerator was now being replaced and the insulin that had been in the refrigerator were now being stored in the Brandon Boulevard medication refrigerator.	F 761	**F801 Qualified Dietary Staff** The Food Service Supervisor (FSS) achieved his Food Protection Manger Certification from ServSafe on January 29,2020 and this certification expires on January 29,2025. Please see attached proof of certification. The Chief Operating Officer or designee will review all certifications of the FSS annually to ensure proper education/certification is maintained. **Compliance Date November 12, 2021**	
F 801 SS=C	Surveyor: Kendall, Jane Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by	F 801	**TAG F 801 POC Accepted on 11/19/21 G. Mercure/P. Cota**	

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F 801	Continued From page 18 an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the	F 801		

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F 801	Continued From page 19 course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to ensure that the director of food and nutrition services (FSD) had required qualifications. Findings include: Per interview with the FSD on 10/20/2021 at 2:15 PM S/he does have training and multiple years of experience in food service, S/he does not have the required qualifications to meet the regulation. During interview with the facility Administrator on 10/20/2021 at approximately 2:30 PM confirmation was made that the FSD did not have the required qualifications for the position. S/he stated that the FSD was recently hired for the position and would be obtaining the required qualifications within the next 6 months.	F 801		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		

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F 812	Continued From page 20 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to store food in accordance with professional standards for food service safety. During the initial tour of the kitchen on 10/18/2021 at approximately 11:40 AM a pan of raw chicken breasts was observed on the bottom shelf of a food storage rack in the walk-in cooler. The raw chicken was only partially wrapped in plastic wrap exposing the chicken to the environment. There was also no date on the plastic wrap to indicate when the chicken should be used by or discarded. Observation of the walk-in freezer revealed three bags of frozen precooked shrimp and one bag of frozen potato cakes that were not dated. During interview on 10/18/21 at approximately 11:45 AM the Food Service Director, confirmed that the raw chicken was uncovered and that all the above noted items should have been covered and labeled with the date of preparation or the date of discard.	F 812	**F812 Food Procurement, Store/Prepare/Serve-Sanitary** **All food items no labeled or stored properly were disposed of.** **Education for all staff on the proper labeling and storage of food began on November 9, 2021 and will continue to until all staff are educated.** **Weekly random audits of food storage areas will take place to identified expired, unlabeled or improperly stored food. The results of will be brought to the QAPI meeting every other month for six months or until the committee determines resolution.** **Compliance Date November 12, 2021** **TAG F 812 POC Accepted on 11/19/21 G. Mercure/P. Cota**	

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F 812	Continued From page 21 On 10/20/2021 at 11:20 AM observation of the "Country Kitchen" off the Dirks Room revealed two bowls of some type of desert, an opened container of chocolate milk, an opened container of white milk, and an opened container of apple juice. None of these items were labeled with the date they were opened. On 10/20/2021 at 11:20 AM a licensed nursing assistant confirmed that these items should be labeled with the date when opened. On 10/20/2021 at 2:15 PM the food service director confirmed that it is the facility policy for staff to date food and beverages with the date opened before placing them back in the refrigerator for future use.	F 812		

ServSafe
National Restaurant Association

ServSafe®
CERTIFICATION

Paul Yerke

for successfully completing the standards set forth for the ServSafe® Food Protection Manager Certification Examination, which is accredited by the American National Standards Institute (ANSI)–Conference for Food Protection (CFP).

18908683	5471
CERTIFICATE NUMBER	EXAM FORM NUMBER
1/29/2020	1/29/2025
DATE OF EXAMINATION	DATE OF EXPIRATION

Local laws apply. Check with your local regulatory agency for recertification requirements.

ANSI
ACCREDITED PROGRAM
American National Standards Institute and the Conference for Food Protection ®
#0655

Sherman Brown
Executive Vice President, National Restaurant Association Solutions

In accordance with Maritime Labour Convention 2006, Resolution ADM N 068-2013 (Regulation 3.2, Standard A3.2).

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Contact us with questions at 233 S. Wacker Drive, Suite 3600, Chicago, IL 60606-6383 or ServSafe@restaurant.org.

VERMONT VETERANS' HOME

November 12, 2021

Ms. Pamela M Cota, RN, Licensing Chief
Department of Disabilities, Aging, and Independent Living
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060

Dear Ms. Cota,

Enclosed you will find the plan of correction for the October 20, 2021 recertification survey and complaint investigation . Please do not hesitate to contact me if you should have any questions or concerns.

Sincerely,

Melissa A Jackson, MBA, FACHCA

Melissa A. Jackson, MBA, FACHCA
CEO