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) 564-1612November 22, 2022

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 November 2, 2022**.** 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

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 11/02/2022

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 re-certification survey, by the Division of Licensing and Protection from 10/31/22 through 11/2/2022. 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.** **F657**	
F 000	INITIAL COMMENTS An unannounced on-site annual re-certification survey was conducted by the Division of Licensing and Protection on 10/31 -11/2/2022. There were regulatory violations identified as a result of this survey.	F 000	**Resident #38's care plan was updated to reflect current provider orders for hydration. All medical records were audited to identify any other residents with similar orders to ensure compliance with this Ftag. No additional residents were identified.** **Staff education on updating care plans began on November 22, 2022 and remains on going.**	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657	**The Director of Nursing Services or designee will conduct four (4) random audits, as outlined below, to ensure care plans are updated appropriately: Weekly x 4 weeks, twice a month X 2 months and monthly x 3 months.** **Audit results will be reviewed at every other month QAPI meeting x 6 months and will continue until the committee determines sustained compliance.** **Compliance Date: December 17, 2022** F657 POC Accepted on 11/22/2022 by S.Freeman/P.Cota	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa A. Jackson MBA, LNHA FACHCA TITLE: CEO (X6) DATE: 11/22/22

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 657	Continued From page 1 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to revise the plan of care to include providing additional fluids for one resident (Resident #38) of 38 residents sampled. Findings include: On October 12, 2022 Resident #38 was sent to the emergency room for evaluation of decreased responsiveness. The resident was returned to the facility after receiving treatment including 1 liter of intravenous fluid. Based on concerns regarding hydration status the provider wrote an order on October 13, 2022, for nursing to sign off that Resident #38 received 1500 ml's (milliliters) of fluid on the first and second shifts. The medication administration record was reviewed from October 14-October 31, 2022 where it was noted of 34 opportunities to provide the resident the ordered 1500 ml this goal was met 11 times and missed 23 times. Resident #38's plan of care was reviewed and it was noted the care plan had not been revised to include the provision of additional fluids. On 11/1/22 the unit manager confirmed the plan of care should have been revised to provide this direction for the nursing staff but had not been.	F 657	**F692** **Resident #38's fluid intake is now recorded in the medication administration record. The MD has updated to clarify that the total daily ml intake is to be 1500ml and that the physician will be updated if Resident #38 consumes >500ml per day.** **Staff education on hydration and physician notification began on November 22, 2022, and remains on going** **The Director of Nursing Services or designee will conduct random audits, as outlined below, to ensure daily fluid intake has been documented and physician notification has taken place when fluid intake is >500ml daily: Weekly x 4 weeks, twice a month X 2 months and monthly x 3 months.** **Audit results will be reviewed at every other month QAPI meeting x 6 months and will continue until the committee determines sustained compliance.** **Compliance Date: December 17, 2022**	
F 692	Nutrition/Hydration Status Maintenance	F 692		

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F 692 SS=D	Continued From page 2 CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide sufficient fluid intake to maintain proper hydration and health for one resident (#38) of 38 residents sampled findings include: On 10/12/22 Resident #38 was noted to become increasingly drowsy with slowed response to stimulation and was sent to the emergency room where he/she received treatment including 1 liter of intravenous fluid and was returned to the facility. After a discussion between the provider and Resident #38's spouse who expressed	F 692	Tag F692 POC Accepted on 11/22/2022 by S.Freeman/P.Cota	

PRINTED: 11/15/2022
FORM APPROVED
OMB NO. 0938-0391

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F 692	Continued From page 3 concern regarding Resident #38 not receiving adequate fluids which may have led to his/her requiring emergent care an order was placed for nursing staff to sign off indicating the resident received 1500 milliliters of fluids every first and second shift. The medication administration record was reviewed from October 14-October 31, 2022 where it was noted of 34 opportunities to provide the resident the ordered 1500 ml this goal was met 11 times and missed 23 times. On 11/1/22 the unit manager confirmed there were no other places the information may have been documented and that the ordered amounts had not been provided. When asked as to his/her expectation if an order cannot be followed he/she replied the expectation would be a nurses note and notification of the provider, he/she confirmed this had not been done.	F 692	**F812** **Maintenance has inspected all refrigerators to ensure they are operating appropriately and can maintain required temperatures. Updated daily temperature logs that include minimum and maximum temperatures and instructions on what to do when the temperatures are out of compliance have been instituted.** **Education for all staff on proper refrigerator/freezer temperatures, daily documentation of temperatures, and notification of maintenance when issues are identified began on November 7, 2022 and is ongoing.** **The Chief Executive officer or designee will conduct temperature audits and maintenance requests audits based on the following schedule: weekly x 4 weeks, every 2 weeks x 2 and monthly x 4 monthly** **Audit results will be reviewed at every other month QAPI meeting x 6 months and will continue until the committee determines sustained compliance.** **Compliance Date: December 17, 2022**	
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. (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.	F 812		

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F 812	Continued From page 4 §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 upon observation, interview, and record review, the facility failed to ensure refrigerator temperatures on resident units were maintained to prevent the potential for food borne illness. Findings include: Per observation of the resident food/snack refrigerator in the 'Sports Bar' area of the facility's North unit, on 11/2/22 at 11:18 AM, the temperature sensor located on the outside of the refrigerator read "49.5 degrees F. [Fahrenheit]". A review was conducted of the written refrigerator temperature log for the Sports Bar refrigerator. The temperature log includes the notation "Fridge temp 36-40 degrees F. If temperature is out of range, notify maintenance department right away, put out of order sign in the door, inspect and remove items if needed." Review of the temperature log from July 31, 2022, through the date of the survey 11/2/22 revealed the highest temperature recorded as 54.8 degrees F. on 8/15/22, with the temperature reaching over 50 degrees 6 times during the review period. Additionally, no recorded temperature was listed as 41 degrees or below on any date, and no temperatures were recorded in the written log for 24 days during the period reviewed. Per interview with the facility's Administrator [ADM] and the Maintenance Director on 11/2/22	F 812		

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F 812	Continued From page 5 at 12:20 PM, staff are assigned daily to record the resident refrigerator temperatures on all resident units. If the refrigerator's temperatures are out of range [per facility policy "Fridge temp 36-40 degrees F."] the maintenance department is to be notified. Per interview with the Maintenance Director, there is no record that the maintenance department was notified on any date regarding the out of range temperatures during the greater than 3 month period reviewed for the 'Sports Bar' resident refrigerator. Review of the facility's Nursing Schedule reveals a section listing "The following staff is responsible for checking unit refrigerator temps and documenting", with a staff member assigned to each resident unit. Per review of the resident food/snack refrigerator log for the American Way unit for October 2022, temperatures were not recorded as taken on 18 of 31 days. An interview was conducted with the American Way Unit Manager [UM] on 11/2/22 at 11:33 AM. The UM stated that resident refrigerator temperatures are to be recorded twice daily. The UM confirmed that temperatures were missing on 18 of 31 days, and that temperatures were not taken twice daily on any of the 31 days, despite the form having sections for 'AM' and 'PM' on each date. A review was conducted on 11/2/22 of the resident food/snack refrigerator log for the residents' Activities Room for October 2022. The review revealed that temperatures were not recorded as taken on 27 of 31 days. Further review on 11/2/22 revealed no November 2022 temperature log had been initiated.	F 812	Tag F812 POC Accepted on 11/22/2022 by S.Freeman/P.Cota	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 6 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880	**F880** **The facility has developed a Water Management Program which will be reviewed at least annually.** **Staff education on our Water Management Program and Legionella began on November 22, 2022 and remains on going.** **The Chief Operation Officer or Designee will conduct random audits of the maintenance request to ensure any issues/concerns regarding the facility's water supply have been addressed, and if appropriate reviewed by the Water Management Team.** **Audit results will be reviewed at every other month QAPI meeting x 6 months and will continue until the committee determines sustained compliance.** **Compliance Date: December 17, 2022** Tag F880 POC Accepted on 11/22/2022 by S.Freeman/P.Cota	

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F 880	Continued From page 7 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to develop and implement measures to prevent the growth of Legionella and other opportunistic waterborne pathogens in the buildings water systems. Review of the facility's Infection Control Program revealed there were no policies or educational	F 880		

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F 880	Continued From page 8 curriculum in place to ensure the facility had a process in place that ensured an adequate water management program to prevent the growth of Legionella or other opportunistic waterborne pathogens. Interview on 11/2/22 at 2:40 PM with the Infection Control Nurse and the Director of Nurses confirmed that the facility's current Infection Control Program did not include measures to educate staff on the prevention of Legionella or a system to monitor the facility's water systems for potential opportunistic waterborne pathogens, to include Legionella.	F 880		

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