

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

August 15, 2012

Ms. Melissa Jackson, Administrator
Vermont Veterans' Home
325 North Street
Bennington, VT 05201-5014

Provider #: 475032

Dear Ms. Jackson:

Enclosed is a copy of your acceptable plans of correction for the follow-up survey conducted on **July 17, 2012**. 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

PC:ne

Enclosure



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

PRINTED: 07/30/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 07/17/2012
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NAME OF PROVIDER OR SUPPLIER VERMONT VETERANS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 325 NORTH STREET BENNINGTON, VT 05201
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{F 000}	INITIAL COMMENTS An unannounced on-site follow-up survey was completed by the Division of Licensing and Protection on 7/17/12. The following are regulatory violations:	{F 000}	Please note that the filing of this plan of correction does not constitute any admission as to any of the alleged violations set forth in this Statement of Deficiency. The POC is being filed as evidence of the Facility's continued compliance with all applicable laws.	
{F 281} SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide or arrange services that meet professional standards for two residents (Residents #1 & #2) by failing to accurately document medication administration and failing to give medications as ordered. Findings include: 1. Per record review, Resident #1 was scheduled to be transported to the Albany Veteran Affairs Hospital (AVA) on 7/5/12 for a doctor's appointment. Per record review of Nursing Notes for Resident #1 on 7/5/12, marked '12:15 - 1630' (4:30 P.M.), "Veteran went to AVA during these hours with this writer...Ibuprofen 600 mg [milligrams] given PO [by mouth] for pain". The Nursing Note at 4:30 P.M. records "Valium 5 mg PO given PRN [as needed] per request". The next Nursing Note at 5:00 P.M. lists "SPV [Supervisor], DON [Director of Nursing] and Administrator aware of above as well as CCC [Clinical Care Coordinator]." Per record review on 7/17/12 there are no initials on Resident #1's Medication Administration Record (MAR) recording Ibuprofen having been given while out	{F 281}	F281 <u>Corrective Action:</u> 1. Nurse corrected documentation on PRN MAR of Resident #1 of ibuprofen and Valium which was administered per his MD order while out on pass. It was verified that medication carbidopa/levadopa (a drug to treat Parkinson's disease) was preordered, obtained and administered per MD order while resident was out on pass and documented per the facility medication administration policy. 2. Nurse corrected missing documentation on the front of the medication record of Resident #2 for clonazepam which corresponds with the nurse's documentation on the Nurses' Medication Notes on the reverse side of the medication record and the narcotic medication log and educated on need to contact MD upon resident return to the facility and document same in the medical record. <u>Other Residents:</u> All Residents are at risk. <u>Systemic Changes:</u> All nurses will be educated on the revised policy specifying how to	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Melissa A Jackson BSW, RN, NHA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/7/12</i>
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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 281)	<p>Continued From page 1</p> <p>on pass or Valium 5 mg having been given on 7/5/12. Per interview on 7/17/12 at 3:30 P.M. the DON confirmed the nurse's administration of both the Ibuprofen and the Valium should have been initialed on the MAR per facility protocol but were not.</p> <p>2. Per record review, Carbidopa/Levodopa (a drug used to treat Parkinson's Disease) is initialed on Resident #1's MAR as being given to the resident while out on pass at 1:30 P.M. on 7/5/12. The DON confirmed the nurse had documented in h/her notes the medications h/she had given to Resident #1, but did not document Carbidopa/Levodopa. The DON agreed that since the nurse was out of the facility at 1:30 P.M., it would not be possible for h/her to obtain and administer that medication to Resident #1, and that the charting was done in error.</p> <p>3. Per record review, Resident #2's Nurse's Medication Notes on 7/8/12 at 11:59 A.M. state "PO [by mouth] Clonazepam [used to treat anxiety disorder] 0.5 mg requested, increased anxiety/nerves". Per record review of Resident #2's MAR for 7/8/12, there is no dose of Clonazepam 0.5 mg initialed as being administered. Per interview at 3:31 P.M. on 7/17/12 the DON confirmed the nurse's administration of the Clonazepam to Resident #2 should have but initialed on the MAR per facility policy but was not.</p> <p>4. Per record review, Resident #2, whose diagnoses include seizure disorder, anxiety, depression, hypertension and dizziness, was transported from the facility to the Emergency Department (ED) at Southwestern Vermont</p>	(F 281)	<p>document medication administration for residents out on pass with a nurse. All nurses will be educated on the revised Admission, Readmission, Return Policy specifying notification of MD upon return from the emergency department and documentation of same in medical record.</p> <p><u>Monitoring:</u> CCCs will audit all MARs and TARs weekly for missed documentation. IDT will review 100% of records where resident required medications while on transport and returns from the emergency department to assure appropriate notification and documentation in place x 90 days. Audit results will be reviewed at the bimonthly QA meeting.</p> <p><u>Compliance Date:</u> August 11, 2012</p> <p><i>F281 Poc accepted 8/9/12 TDougherty Rul Pmc</i></p>	

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{F 281} Continued From page 2
Medical Center (SVMC) after noon on 7/8/12 for evaluation of right hip pain. Resident #2 returned from SVMC to the facility at 7:45 P.M. During the time Resident #2 was gone from the facility, 4 medications; Percocet (a narcotic pain reliever), Baclofen (used to treat muscle spasms), Buspirone (an anti-anxiety drug), and Docusate Sodium (a stool softener) scheduled for 4:00 P.M., were not administered because the resident was unavailable until 7:45 P.M. Per record review Nurse's Medication Notes on 7/8/12 "1600 [4:00 P.M.] all meds held. Vet out to ED". Per interview with the DON at 3:31 P.M. on 7/17/12, it is h/her expectation that Resident #2's nurse would contact the physician, after the resident had returned, regarding what to do about the missed doses of medications. The DON confirmed there was no documentation that Resident #2's physician had been contacted regarding the missed medications, and indicated that the medications were significant and necessary for Resident #2's well being.

{F 281} **F282**
Corrective Action:
1. Facility verified that medication carbidopa/levadopa (a drug to treat Parkinson's disease) was preordered, obtained and administered per MD order while Resident #1 was out on pass and documented on the MAR per the facility medication administration policy.
2. Nurse educated on requirement to contact MD upon resident return to the facility from the emergency department and document same in the medical record.

Other Residents:
All Residents returning from the emergency department are at risk.

{F 282} 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
SS=D
The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to provide services in accordance with the resident's plan of care for two residents (Residents #1 & #2) by failing to give medications as ordered. Findings include:

{F 282} **F282**
Systemic Changes:
All nurses will be educated on the revised Admission, Readmission, Return Policy specifying notification of MD upon return from the emergency department and documentation of same in medical record.

Monitoring:
IDT will review 100% of records where resident returned from the emergency department to assure MD notification performed and appropriate documentation in place x 90 days. Audit results will be reviewed at the bimonthly QA meeting

Compliance Date:
August 11, 2012

*FABA POC accepted 8/9/12
TDougherty RN/PMC*

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{F 282}	<p>Continued From page 3</p> <p>1. Per record review, Resident #1, whose diagnoses include Parkinson's Disease, Congestive Heart Failure, Atypical Chest Pain, Depression, Dementia, Obesity, Paranoid delusions, Degenerative Joint Disease, Tremors, and Post Traumatic Stress Disorder, has a Plan of Care that includes: "administer medications as ordered by provider". Per record review, Carbidopa/Levodopa (a drug used for Parkinson's Disease) is initialed on Resident #1's MAR (Medication Administration Record) as being given to the resident while out on pass at 1:30 P.M. on 7/5/12. Per interview with the Director of Nursing (DON) at 3:31 P.M. on 7/17/12, the DON confirmed the nurse had documented in h/her notes the medications h/she had given to Resident #1, but did not document Carbidopa/Levodopa. The DON agreed that since the nurse was out of the facility at 1:30 P.M., it would not be possible for h/her to obtain and administer that medication to Resident #1, and that the charting was done in error.</p> <p>2. Per record review, Resident #2, whose diagnoses include seizure disorder, anxiety, depression, hypertension and dizziness, has a Plan of Care which includes the intervention "administer medications as ordered by provider". Per record review, Resident #2 was transported from the facility to the Emergency Department (ED) at Southwestern Vermont Medical Center (SVMC) after noon on 7/8/12 for evaluation of right hip pain. Resident #2 returned from SVMC to the facility at 7:45 P.M. During the time Resident #2 was gone from the facility, 4 medications: Percocet (a narcotic pain reliever), Baclofen (used to treat muscle spasms).</p>	{F 282}		

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{F 282}	Continued From page 4 Buspirone (an anti-anxiety drug), and Docusate Sodium (a stool softener) scheduled for 4:00 P.M., were not administered because the resident was unavailable until 7:45 P.M. Per record review Nurse's Medication Notes on 7/8/12 "1600 [4:00 P.M.] all meds held. Vet out to ED". Per interview with the DON at 3:31 P.M. on 7/17/12, it is h/her expectation that Resident #2's nurse would contact the physician, after the resident had returned, regarding what to do about the missed doses of medications. The DON confirmed there was no documentation that Resident #2's physician had been contacted regarding the missed medications, and indicated that the medications were significant and necessary for Resident #2's well being.	{F 282}		
{F 490} SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility is not administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. (Resident #1) Findings include: 1. Per record review, the facility submitted a Plan Of Correction (POC) for regulatory violations with	{F 490}	<p>F490 <u>Corrective Action:</u> 1. Medication Administration -On July 18, 2012 The Out on Pass policy was updated to include the specific procedure for documentation of medications administered while a nurse is out on pass with a resident. All nurses are being educated on the updated policy. 2. Nurse corrected documentation on PRN MAR of Resident #1 of ibuprofen and Valium which was administered per his MD order and documented in the nursing notes while out on pass. 3. Facility verified that medication carbidopa/levadopa (a drug to treat Parkinson's disease) was preordered, obtained and administered per MD order while Resident #1 was out on pass and documented on the MAR per the facility medication administration policy. 4. Audit was re-performed and corrected to reflect that the PRN medications for Resident #1 were not initialed in the resident medication administration record and audit discrepancy was reviewed as education with personnel performing audits. 5. Nurse educated on requirement to contact MD upon resident return to the facility from the emergency department and document same in the medical record.</p> <p><u>Other Residents:</u> All Residents are at risk.</p>	

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{F 490}	<p>Continued From page 5</p> <p>the approved compliance date of 6/27/12. Included in the Systemic Changes in the POC for all of the regulatory violations is "Education to all nurses...regarding obtaining and documenting medications while resident is out on pass." Per record review of the facility's policy for Medication Administration - Out on Pass, dated 6/21/12, there is no reference or statement regarding how nurses are to document medications given while the resident is out on pass. Per interview on 7/17/12 at 3:30 P.M., the Director of Nursing (DON) stated the facility's protocol is for the nurse administering the medications to take the resident's MAR (Medication Administration Record) with them while out on pass and initial when the resident had received their medications, or to make a copy of the MAR and initial on that, then transcribe the information to the original MAR after returning to the facility.</p> <p>The DON confirmed there are no written instructions in the facility's policy regarding documenting medications while the resident is out on pass, and confirmed there had been no education given to nurses on how to do so. Per interview with 3 of the facility's nursing staff and a unit Clinical Care Coordinator (CCC) on 7/17/12 at 1:10 P.M., staff confirmed they had received no education regarding documenting medications while a resident is out on pass, and had no knowledge of the facility's procedure on how to do so.</p> <p>2. Per record review, Resident #1 was scheduled to be transported to the Albany Veteran Affairs Hospital (AVA) on 7/5/12 for a doctor's appointment. Per record review of Nursing Notes for Resident #1 on 7/5/12, marked '12:15 - 1630'</p>	{F 490}	<p><u>Systemic Changes:</u> Medication Administration – On July 18, 2012 The Out on Pass policy was updated to include the specific procedure for documentation of medications administered while a nurse is out on pass with a resident. All nurses are being educated on the updated policy.</p> <p><u>Monitoring:</u> CCCs will audit all MARs and TARs weekly for missed documentation. IDT will review 100% of records where resident required medications while on transport and returns from the emergency department to assure appropriate notification and documentation in place x 90 days. Administrator or designee and DNS or designee will re-audit 25% of records audited for residents requiring medications while out on transport x 90 days to assure accuracy of IDT audits. DNS or designee will re-audit 25% of weekly MAR and TAR audits to confirm accuracy of CCC audits. Audit results will be reviewed at the bimonthly QA meeting.</p> <p><u>Compliance Date:</u> August 11, 2012</p> <p>F490 POC accepted 8/19/12 TDougherty RN/PMC</p>	

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{F 490}	<p>Continued From page 6</p> <p>(4:30 P.M.), "Veteran went to AVA during these hours with this writer...Ibuprofen 600 mg [milligrams] given PO [by mouth] for pain". The Nursing Note at 4:30 P.M. records "Valium 5 mg PO given PRN [as needed] per request". The next Nursing Note at 5:00 P.M. lists "SPV [Supervisor], DON [Director of Nursing] and Administrator aware of above as well as CCC [Clinical Care Coordinator]." Per record review on 7/17/12 there are no initials on Resident #1's Medication Administration Record (MAR) recording Ibuprofen having been given while out on pass or Valium 5 mg having been given on 7/5/12. Per interview on 7/17/12 at 3:30 P.M. the DON confirmed the nurse's administration of both the Ibuprofen and the Valium should have been initialed on the MAR per facility protocol but were not.</p> <p>3. Per record review, Carbidopa/Levodopa (a drug used to treat Parkinson's Disease) is initialed on Resident #1's MAR as being given to the resident while out on pass at 1:30 P.M. on 7/5/12. The DON confirmed the nurse had documented in h/her notes the medications h/she had given to Resident #1, but did not document Carbidopa/Levodopa. The DON agreed that since the nurse was out of the facility at 1:30 P.M., it would not be possible for h/her to obtain and administer that medication to Resident #1, and that the charting was done in error.</p> <p>4. Per record review, the facility's Plan Of Correction (POC) for regulatory violations includes "review of 100% of records where resident required medications while on transport to assure appropriate personnel and</p>	{F 490}		

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{F 490}	<p>Continued From page 7</p> <p>documentation in place". Per record review of the facility's Out on Medical Pass with Medications Audit dated 7/2 - 7/8/12, the audit of documentation of Resident #1's transport on 7/5/12 reports "follow up needed- none", indicating that there was no follow up needed after the audit. Per interview on 7/17/12 at 3:30 P.M., the DON confirmed that the audit was inaccurate, that the errors in medication documentation for Resident #1 should have appeared on the audit, and that the audit would have to be redone.</p> <p>5. Per record review, Resident #2, whose diagnoses include seizure disorder, anxiety, depression, hypertension and dizziness, was transported from the facility to the Emergency Department (ED) at Southwestern Vermont Medical Center (SVMC) after noon on 7/8/12 for evaluation of right hip pain. Resident #2 returned from SVMC to the facility at 7:45 P.M. During the time Resident #2 was gone from the facility, 4 medications; Percocet (a narcotic pain reliever), Baclofen (used to treat muscle spasms), Buspirone (an anti-anxiety drug), and Docusate Sodium (a stool softener) scheduled for 4:00 P.M., were not administered because the resident was unavailable until 7:45 P.M. Per record review Nurse's Medication Notes on 7/8/12 "1600 [4:00 P.M.] all meds held. Vet out to ED". Per interview with the DON at 3:31 P.M. on 7/17/12, it is h/her expectation that Resident #2's nurse would contact the physician, after the resident had returned, regarding what to do about the missed doses of medications. The DON confirmed there was no documentation that Resident #2's physician had been contacted regarding the missed medications, and indicated</p>	{F 490}		

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(F 490) F 514 SS=D	<p>Continued From page 8 that the medications were significant and necessary for Resident #2's well being.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized by failing to maintain accurate medication administration documentation for two residents (Residents #1 & #2). Findings include:</p> <p>1. Per record review, Resident #1 was scheduled to be transported to the Albany Veteran Affairs Hospital (AVA) on 7/5/12 for a doctor's appointment. Per record review of Nursing Notes for Resident #1 on 7/5/12, marked '12:15 - 1630' (4:30 P.M.), "Veteran went to AVA during these hours with this writer...Ibuprofen 600 mg</p>	(F 490) F 514	<p>F514 <u>Corrective Action:</u></p> <ol style="list-style-type: none"> 1. Nurse corrected missing documentation on medication record of Resident #1 of ibuprofen and Valium which was administered per his MD order and documented in the nursing notes while out on pass. 2. Facility verified that medication carbidopa/levadopa (a drug to treat Parkinson's disease) was preordered, obtained and administered per MD order while Resident #1 was out on pass and documented on the MAR per the facility medication administration policy. 3. Nurse corrected missing documentation on the front of the medication record of Resident #2 for clonazepam which corresponds with the nurse's documentation on the Nurses' Medication Notes on the reverse side of the medication record and the narcotic medication log. <p><u>Other Residents:</u> All Residents are at risk.</p> <p><u>Systemic Changes:</u> Medication Administration - Out on Pass policy was updated to include the specific procedure for documentation of medications administered while a nurse is out on pass with a resident on July 18, 2012. All nurses are being educated on the updated policy.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 07/17/2012
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NAME OF PROVIDER OR SUPPLIER VERMONT VETERANS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 325 NORTH STREET BENNINGTON, VT 05201
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F 514 Continued From page 9
[milligrams] given PO [by mouth] for pain". The Nursing Note at 4:30 P.M. records "Valium 5 mg PO given PRN [as needed] per request". The next Nursing Note at 5:00 P.M. lists "SPV [Supervisor], DON [Director of Nursing] and Administrator aware of above as well as CCC [Clinical Care Coordinator]." Per record review on 7/17/12 there are no initials on Resident #1's Medication Administration Record (MAR) recording Ibuprofen having been given while out on pass or Valium 5 mg having been given on 7/5/12. Per interview on 7/17/12 at 3:30 P.M. the DON confirmed the nurse's administration of both the Ibuprofen and the Valium should have been initialed on the MAR per facility protocol but were not.

2. Per record review, Carbidopa/Levodopa (a drug used to treat Parkinson's Disease) is initialed on Resident #1's MAR as being given to the resident while out on pass at 1:30 P.M. on 7/5/12. The DON confirmed the nurse had documented in h/her notes the medications h/she had given to Resident #1, but did not document Carbidopa/Levodopa. The DON agreed that since the nurse was out of the facility at 1:30 P.M., it would not be possible for h/her to obtain and administer that medication to Resident #1, and that the charting was done in error.

3. Per record review, Resident #2's Nurse's Medication Notes on 7/8/12 at 11:59 A.M. state "PO [by mouth] Clonazepam [used to treat anxiety disorder] 0.5 mg requested, increased anxiety/nerves". Per record review of Resident #2's MAR for 7/8/12, there is no dose of Clonazepam 0.5 mg initialed as being administered. Per interview at 3:31 P.M. on

F 514 All nurses are being educated on the expectation that documentation of medications must be completed including initials on the face of the medication record, narcotic log and nursing notes for as needed medications.

Monitoring:
CCCs will audit all MARs and TARs weekly for missed documentation. DNS or designee will re-audit 25% of weekly MAR and TAR audits to confirm accuracy of CCC audits. Audit results will be reviewed at the bimonthly QA meeting.

Compliance Date:
August 11, 2012

*F514 PIC accepted 8/9/12
T.Dougherty RAI Pmc*

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 07/17/2012
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NAME OF PROVIDER OR SUPPLIER VERMONT VETERANS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 325 NORTH STREET BENNINGTON, VT 05201
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F 514	Continued From page 10 7/17/12 the DON confirmed the nurse's administration of the Clonazepam to Resident #2 should have but initialed on the MAR per facility policy but was not.	F 514		
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