



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

June 25, 2010

Colleen Rundell, Administrator
Vermont Veterans Home
325 North Street
Bennington, VT 05201

Provider #: 475032

Dear Ms. Rundell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 19, 2010**. Please post this document in a prominent place in your facility.

We will 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,

Suzanne Leavitt, RN, MS
Assistant Director

Enclosure



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

RECEIVED
Division of

PRINTED: 06/01/2010
FORM APPROVED
OMB NO. 0938-0391

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Licensing and
Protection

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 05/19/2010
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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	F 000	F 166	
F 166 SS=D	<p>A recertification survey was conducted by the Division of Licensing and Protection on 05/17/10 - 05/19/10. The following regulatory violations were found.</p> <p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to promptly seek a resolution to a complaint for 1 applicable resident. (Resident #120) Findings include:</p> <p>1. Per an initial interview on 5/17/10 at 11:30 AM., Resident #120 stated to the State surveyor that s/he made a complaint several months ago about the room being uncomfortably hot and that it has not been addressed . Per review of the facility's policy Concern-Complaint PRC: all concerns will be investigated by the Social Services Department as well as the appropriate department with documentation of action and will be returned to Administration for final review and approval. Per interview on 5/19/10 at 8:45 AM the Maintenance Director stated that he spoke to Resident #120 (on February 1, 2010) regarding a new heating/cooling system being installed in May 2010 but did not have a resolution at that time. The Quality Assurance Coordinator confirmed during interview on 5/19/10 at 2:00 PM that a</p>	F 166	<p>Assuming for the moment that the finding and determination of deficiency are accurate without admitting or denying that they are, our proposal for corrective action is as follows:</p> <p>Resident #120 was interviewed by the staff and he continued to express a complaint regarding the heat in his room. An air conditioner was immediately installed but later removed at the Veteran's request.</p> <p>The grievance policy was reviewed and found to remain appropriate.</p> <p>All residents on the "A" Wing of the Vermont Veterans' home have the potential to be affected by the same alleged practice.</p> <p>The following measures will be taken to ensure that the identified practice does not recur: All department heads and the "A" wing clinical care coordinator were directed by administrative directive to meet the regulatory requirement to address Veteran/Member grievances promptly and to follow the VVH grievance policy and procedure. Additionally, all nursing staff on the "A" Wing will be re-inserviced by the Clinical Care Coordinator, or designee, on the grievance policy and procedure.</p> <p>These corrective actions will be monitored in the following manners: The Assistant Administrator will be responsible to audit all grievances documented with the grievance form to ensure that the regulatory expectation for prompt resolution is met. The audits will be completed once weekly for 60 days. Identified non-compliance will be immediately rectified. Additionally, results of the audits will be reviewed by the Assistant Administrator and trends identified. The outcomes and trends will be reported to the quality assurance committee by the Assistant Administrator for further review and recommendations that may include further education, disciplinary action, etc...</p> <p>The Assistant Administrator will be responsible for this plan of correction.</p>	<p>5/17/10</p> <p>5/19/10</p> <p>Attachment #1 6/14/10</p> <p>6/18/2010</p> <p>attachment #2</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Cohen Rudell

Administrators

FILE 6-24-10

(X6) DATE

6/14/10

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 166	Continued From page 1	F 166		
F 252 SS=E	<p>resolution nor the problem was addressed promptly.</p> <p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility did not have chairs available in resident rooms to provide a home-like environment for residents of the facility. Findings include:</p> <p>Per observation during 3 days of survey, the facility was noted to have no seating arrangements for residents in their rooms in 5 of 11 rooms observed on 1 unit. Two of the other 6 rooms on that unit did have a chair available for one resident but 2 residents occupied each of those rooms. Other units were also noted to not have chairs in the resident rooms and residents were observed at various times of the day sitting on their beds. When questioned, those who were interviewable, indicated that they had no place else to sit. Per purchase order provided to the State surveyors on 05/19/2010 at 12:30 pm, 90 residents of the 148 currently residing in the facility have no seating arrangements other than in the community areas.</p> <p>Per staff interviews on both 5/18/2010 and 05/19/2010 it was confirmed that chairs are able to be brought to the rooms from other areas on</p>	F 252	<p>F252</p> <p>The Vermont Veterans Home will note the following. There is an inaccurate statement in the statement of deficiencies. Though the home is currently purchasing 90 chairs, that is not indicative of the number of chairs needed for Veterans' rooms. The home is also purchasing chairs for a unit that is not in use at this time and for common areas of the building.</p> <p>Assuming for the moment that the finding and determination of deficiency are accurate without admitting or denying that they are, our proposal for corrective action is as follows:</p> <p>A Purchase Order has been submitted to the State of Vermont to purchase chairs for resident rooms.</p> <p>29 Veterans of the Vermont Veterans' Home have the potential to be affected by this alleged deficient practice.</p> <p>The following systemic change has been made to ensure that the identified practice does not recur:</p> <p>Staff has been directed by administrative memo to not remove chairs from Veterans'/Members' rooms.</p> <p>These corrective actions will be monitored in the following manners: The Housekeeping supervisor will audit 10 Veteran/Member rooms per week for 90 days to ensure chairs are available for personal use. Identified non-compliance will be immediately rectified. Audit results will be reviewed by the Housekeeping Supervisor and trends identified. The outcomes and trends will be reported to the quality assurance committee by the Housekeeping Supervisor for further review and recommendations that may include further education, disciplinary action, etc...</p> <p>The Housekeeping Supervisor will be responsible for this plan of correction.</p> <p><i>Accepted 6-24-10</i></p>	<p>5/19/10 Attachment #3</p> <p>6/14/10 Attachment #4</p> <p>Attachment #5</p>

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F 252	Continued From page 2	F 252		
F 281 SS=D	<p>the unit if staff are asked but that it is not customary to have chairs in the resident rooms.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide services in accordance with professional standards of nursing practice by failing to consistently assess pain for 1 of 14 residents in the sample. (Resident #71) Findings include:</p> <p>1. Per record review on 5/19/10 Resident #71 did not have consistent documentation of having pain assessed daily. Physician's orders stated to assess pain daily, as well as being care planned for daily pain scale assessment. Per review of the medical record, Resident #71 complained on 4/18/10 of not sleeping "because his legs ached all night." Per review of the Medication Administration Record (MAR)/Treatment Administration Record (TAR), as well as the nursing notes, there was no documentation that the pain was assessed on 4/18/10. In addition, 5 days in March and 6 days in April were not documented as having pain assessments completed for this resident. Per interview on 5/19/10 at 11:45 AM the clinical coordinator confirmed that there was not consistent documentation to determine if pain was assessed daily.</p>	F 281	<p>F281 Assuming for the moment that the finding and determination of deficiency are accurate without admitting or denying that they are, our proposal for corrective action is as follows:</p> <p>Veteran # 71 was assessed for pain with the use of the Stage II Critical Elements for Pain Management. The Veteran was assessed by the Medical Director on 5/28/10 and his care plan was revised to address pain from an interdisciplinary perspective.</p> <p>All residents on North Wing have the potential to be affected by this alleged deficient practice.</p> <p>The following systemic change has been made to ensure that the identified practice does not recur.</p> <p>The pain policy was reviewed and revised. The North Wing Nursing Staff were educated to ensure that the pain assessment occurred per policy. All nursing staff has been inserviced on the pain policy and procedure.</p> <p>The Director of Nursing or designee will audit weekly, for 60 days, compliance with this plan of correction and its effectiveness. Identified non-compliance will be immediately rectified. Audit results will be reviewed by the Director of Nursing or designee and trends identified. The outcomes and trends will be reported to the quality assurance committee by the Director of Nursing for further review and recommendations that may include further education, disciplinary action, etc...</p> <p>The Director of Nursing is responsible for this plan of correction.</p> <p><i>Revised 6-28-10</i></p>	<p>5/21/10 Attach #6</p> <p>5/21/10 Attach #7</p> <p>Attach #8 5/28/10</p> <p>5/21/10 Attach #8A</p> <p>6/14/10</p> <p>Attach #9</p>
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	<p>Continued From page 3</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to assure that all foods were stored and prepared under sanitary conditions. Findings include:</p> <p>The following kitchen and store room observations were made during the initial tour of the kitchen, accompanied with the Food Service Director (FSD), commencing on 5/17/10 at 11 AM:</p> <p>a. Two fryolators in the kitchen were heavily soiled with a build up of food debris on the sides and the oil was very dark, with a ring of food crumbs around the edges of the vats. b. The manual can opener was visibly soiled, including the cutting blade area and the shaft. c. The shelving in the dry goods store room in the basement area were coated with visible dust. Per interview during the tour, the FSD confirmed that there was not a regular cleaning schedule for the fryolators, can opener and store room shelves.</p> <p>During kitchen observations on 5/18/10 at 9 AM, the fryolators remained soiled with dark brown oil.</p>	F 371	<p>F 371</p> <p>Assuming for the moment that the finding and determination of deficiency are accurate without admitting or denying that they are, our proposal for corrective action is as follows:</p> <p>The fryolators were cleaned. The manual can opener was cleaned. The shelving in the dry goods store room was dusted.</p> <p>All residents of the Vermont Veterans' Home have the potential to be affected by this practice.</p> <p>The following measures have been implemented to ensure that the identified practice does not recur: An Administrative memo was sent to the Food Service Director that directed that fryolators and the manual can opener be cleaned as needed and the dry goods shelving be dusted as needed. These areas were also added to dietary's daily cleaning check list.</p> <p>These corrective actions will be monitored in the following manners: The Food Service Director of desigence will be responsible to audit the areas of non-compliance twice weekly for 60 days to ensure the plan of correction is implemented. Identified non-compliance will be immediately rectified. Audit results will be reviewed by the Food Service Supervisor and the Director of Quality Assurance and trends identified. The outcomes and trends will be reported to the quality assurance committee by the Food Service Supervisor for further review and recommendations that may include further education, disciplinary action, etc...</p> <p>The Food Service Supervisor will be responsible for this plan of correction.</p> <p><i>PC [Signature] 6-24-10</i></p>	<p>5/18/10 5/17/10 5/18/10</p> <p>6/14/10 Attach # 10</p> <p>Attach # 11</p>	

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F 371	Continued From page 4	F 371		
F 372 SS=E	Per interview at that time, the FSD confirmed that the fryolators had not yet been cleaned. 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to dispose of garbage and refuse properly during the 3 days of survey. Findings include: Per observations of the garbage disposal area during the initial tour of the kitchen areas at 11:30 AM on 5/17/10, there was a dumpster containing old equipment, furniture, paper trash and food garbage, with an open top and end area, adjacent to the loading dock outside of the back kitchen door. The Food Service Director (FSD), who was conducting the tour, stated that the dumpster did not belong there and that the food garbage should not have been disposed of in that dumpster. The open dumpster containing this same refuse was observed on 5/18/10 at 9 AM and again on 5/19/10 at 10:45 AM. At that time, the FSD stated that she did not know why it had not been cleaned up yet.	F 372	F 372 Assuming for the moment that the finding and determination of deficiency are accurate without admitting or denying that they are, our proposal for corrective action is as follows: The dumpster that "did not belong" was removed from the premises of the Vermont Veterans' Home. All residents of the Vermont Veterans' Home have the potential to be affected by this practice. The following measures have been implemented to ensure that the identified practice does not recur: An Administrative memo was sent to the Food Service Supervisor directing that the proper dumpster be used to dispose of food garbage and that the entry door is kept closed. These corrective actions will be monitored in the following manners: The Food Service Supervisor and/or designee will be responsible to audit the dumpster twice weekly for 60 days to ensure that this plan of correction is implemented. Identified non-compliance will be immediately rectified. Audit results will be reviewed by the Food Service Supervisor and trends identified. The outcomes and trends will be reported to the quality assurance committee by the Food Service Supervisor for further review and recommendations that may include further education, disciplinary action, etc... The Food Service Supervisor will be responsible for this plan of correction. <i>Be again 6-24-10</i>	5/19/10 6/14/10 Attach # 10 Attach # 11