

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

February 6, 2014

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 **January 22, 2014**. 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:jl

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

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  C 01/22/2014
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	The filing of this plan of correction does not constitute an admission of guilt. Vermont Veterans' Home ("the Provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements.	
F 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 record review and staff interview, the facility failed to assure that the professional standards were met regarding following physician orders for 3 of 4 residents reviewed. (Residents #1, #2 and #4) Findings include:  1. Per record review, Resident #1 has a physician order for daily suprapubic catheter care which includes cleansing and application of dressing. Review of the treatment sheet presents that on November 10, 2013 and November 23, 2013, there were omissions of initials from staff assigned to complete the task. There is no documentation on the back of the treatment record or in the nursing progress notes to indicate the reason treatment not done. November 17 and 18 have initials indicating treatment was completed; but on back of treatment record, there are statements by the nurses assigned that indicate treatment was not done secondary refusal on 18th and being "pulled off unit while preparing to do treatment" and "pulled off unit to go to B wing thereafter so couldn't go back for another offer".	F 281	F281 Services Provided Meet Professional Standards  Residents #1, #2 & #4 evaluated by the CCC and DNS. The Nurses missing documentation have been educated about nursing practice standards of documentation, which includes treatments and refusal of treatments as well as alerting another staff member if treatments will not be able to be completed.  All residents' treatment records have been audited and documented omissions are followed up with individual education about nursing practice standards of documentation. General education regarding Treatment Administration Record documentation has begun and will continue for the nurses of the facility.  Going forward, nursing staff will audit each other's documentation of treatments at shift change to ensure accurate documentation of treatments is occurring. The nursing staff will sign off on the "treatment documentation sign off sheet" that is maintained at the front of the treatment binder. The CCC or Nursing Supervisor will randomly audit the treatment administration record documentation and sign-off sheet to ensure compliance.	2/5/14 cc

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Christina Culhane</i>	TITLE Director of Nurse Services	(X6) DATE 2/5/14
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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 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.

PML

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FORM APPROVED  
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
FOR MEDICARE & MEDICAID SERVICES

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F 281	<p>Continued From page 1</p> <p>Per interview with nurse assigned to do treatment on 1/18th on 1/22/14 at 12:47 AM, h/she stated that it is the policy of the facility to alert another staff member if unable to complete treatments. H/she also stated that if a treatment isn't done, it is to be circled and a note to indicate why it wasn't done is to be written. This was confirmed by the DON and Clinical Care Coordinator (CCC) at 11:45 AM.</p> <p>2. Per record review, Resident # 2 has a physician order for skin prep to left heel daily. Treatment record presents with omissions on 1/1 and 1/2/14. There is no indication on the back of the treatment record or in the nurse progress note to indicate the reason why the treatment was not done. This was confirmed with the DON and CCC on 1/22/14 at 11:45 AM.</p> <p>3. Per record review, Resident # 4 has a physician order for skin prep daily to right heel with omissions on the treatment record for 1/12 and 1/19/14. There are also omissions of initials for physician-ordered A&amp;D with Zinc to groin every shift as well as application of Antifungal cream to be applied prior to application of A&amp;D, on 1/9/14. Physician order to elevate right heel off bed to avoid all pressure to heel had omissions on 1/9, 1/17 and 1/19/14. There was no documentation to present reason for treatments not being done. Confirmation was made on 1/22/14 at 11:45 AM by the DON and CCC.</p> <p>Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams &amp; Wilkins.</p>	F 281	<p>The treatment documentation and sign off sheet will be further reviewed at the "Focus Meeting" weekly by the Director of Nurses or designee to ensure compliance with documentation and that follow up is occurring.</p> <p>Data from the audits will be brought to the Quality Assurance meeting every other month for six months or until the committee determines resolution.</p> <p>The Director of Nursing is ultimately responsible to ensure that Professional Standards of Care are being maintained.</p> <p><i>F281 POC accepted 2/16/14 BBordell/RM/PML</i></p>	
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F 282 F 282 SS=D	<p>Continued From page 2</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement the care plans for 1 of 4 residents reviewed. (Resident #1) Findings include:</p> <p>Resident #1 has a physician order for daily suprapubic catheter care which includes cleansing and application of dressing. Review of the treatment sheet presents that on November 10, 2013 and November 23, 2013, there were omissions of initials from staff assigned to complete the task. There is no documentation on the back of the treatment record or in the nursing progress notes to indicate the reason treatment not done. November 17 and 18 have initials indicating treatment was completed, but on back of treatment record, there are statements by the nurses assigned that indicate treatment was not done secondary refusal on 18th and being "pulled off unit while preparing to do treatment" and "pulled off unit to go to B wing thereafter so couldn't go back for another offer". Per interview with nurse assigned to do treatment on 18th on 1/22/14 at 12:47 PM, h/she stated that it is the policy of the facility to alert another staff member if unable to complete treatments. H/she also stated that if a treatment isn't done, it</p>	F 282 F 282	<p>F282 Care by Qualified Persons per Care Plan</p> <p>Residents #1, #2 &amp; #4 evaluated by the CCC and DNS and care plans reviewed. The Nurses missing documentation have been educated about nursing practice standards of documentation, which includes treatments and refusal of treatments as well as alerting another staff member if treatments will not be able to be completed.</p> <p>All residents' treatment records have been audited and documented omissions are followed up with individual education about nursing practice standards of documentation. General education regarding Treatment Administration Record documentation has begun and will continue for the nurses of the facility.</p> <p>Going forward, nursing staff will audit each other's documentation of treatments at shift change to ensure accurate documentation of treatments is occurring. The nursing staff will sign off on the "treatment documentation sign off sheet" that is maintained at the front of the treatment binder. The CCC or Nursing Supervisor will randomly audit the treatment administration record documentation and sign off sheet to ensure compliance.</p> <p>The treatment documentation and sign off sheet will be further reviewed at the "Focus Meeting" weekly by the Director of Nurses or designee to ensure compliance with documentation and that follow up is occurring.</p>	2/5/14 CL

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F 282	Continued From page 3 is to be circled and a note to indicate why it wasn't done is to be written. This was confirmed by the DON and Clinical Care Coordinator (CCC). Resident #1 has care plans regarding suprapubic catheter care listed under Bowel Management/ Risk of Skin Integrity and Dehydration. Confirmation was given by the DON and CCC at 11:45 AM that the care plans were not followed by failure to do the treatment as ordered.	F 282	Data from the audits will be brought to the Quality Assurance meeting every other month for six months or until the committee determines resolution.  The Director of Nursing is ultimately responsible to ensure that Professional Standards of Care are being maintained.  <i>F282 POC accepted 2/11/14 BBorkerRN/pmc</i>	