

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

April 7, 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 **March 12, 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

PRINTED: 03/24/2014
FORM APPROVED
OMB NO. 0938-0391

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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 C 03/12/2014 |
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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 |
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| F 000 | INITIAL COMMENTS An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 3/11-3/12/14 regarding allegations of employee to resident abuse, resident safety, and staffing. Regulatory violations were identified. | 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 223 SS=G | 483.13(b), 483.13(c)(1)(i). FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based upon interview and record review the facility failed to ensure 1 of 3 residents [Resident #1] remained free from verbal, physical, and mental abuse by staff. Findings include: Per record review on 3/11/14 of witness statements regarding an incident in the Brandon Way dining room of the facility on 2/28/14, Resident #1 had finished h/her meal and attempted to rise from h/her chair, stand, and ambulate with a walker back to h/her room. Per interview with Resident #1 on 3/11/14 at 12:05 P.M. s/he stated, "I'm a fast eater. I like to get up from the mess hall. They yelled at me to sit down. I said I was done eating. They didn't explain anything. They said you've got to sit down and | F 223 | F223 Free From Abuse/Involuntary Seclusion Resident #1 is at baseline function at this time. He has had no changes in daily routine since the incident on 2/28/14. This residents care plan was reviewed and revised to include scheduled Namaste times and structured activities. The facility continues to conduct Background Checks, Registry Checks and Reference Checks for every employee upon hire and provides employees quarterly education on Abuse, Mistreatment and Neglect. LNA #1 was removed from resident care immediately and has been suspended pending the outcome of the investigation. All staff who worked on the Brandon Neighborhood on the evening shift of 2/28/14 is | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *M. Wilson Jackson, BSW, LNA* TITLE *Administrator* (X8) DATE *3/28/14*

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.

PML

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| F 223 | <p>Continued From page 1</p> <p>wait for the rest of them to finish. I said I was done eating and I ain't gonna sit waiting for everyone to finish. Somebody grabbed me. I got punched in the back. A big heavy set kid wrestled me into the chair".</p> <p>Per record review, Witness #1's statement records "At approx. 5:15 pm during dinner ... [LNA #1] was...yelling at [Res. #1] to sit down. This happened 2 or 3 times. [LNA #1] finally stood up, where [h/she] was sitting at the same table, and grabbed [Res. #1's] arms to sit [h/her] down ... [Res. #1] was very upset". Witness #2's statement reports "at around 5:15 P.M. ...[LNA #1] got up from [h/her] chair, walked over, put [h/her] arms around [Res.#1] from behind, had [Res.#1's] arms crossed and had [h/her]forced to sit down. [LNA #1] held [Res. #1] down for a minute before [h/she] stayed sitting down." Witness #3's statement recorded "at approx. 5:15 pm...I heard [LNA #1] yell out '[Res. #1] sit down' in a very stern tone. [LNA #1] then walked behind [Res. #1], crossed [h/her] arms and forced [h/her] to sit down."</p> <p>Per record review of Nursing Notes dated 2/28/14 at 7:00 P.M. "unit nurse reported bruising noted to [Res. #1's] right wrist and left forearm when [Res. #1] returned post dinner".</p> <p>Per record review of Emergency Department documents from the hospital where Resident #1 was later taken on 2/28/14, "The [nursing home] staff stated that an LNA had to forcefully restrain this patient, forcing [h/her] down in [h/her] chair, and apparently applied pressure on the right wrist." The Emergency Department's final diagnosis for Resident #1 was "right wrist sprain".</p> | F 223 | <p>under investigation and discipline will be conducted as a result of the investigation. In addition, these staff members completed education on Abuse, Mistreatment and Neglect and signed an attestation form stating that they understand their reporting obligations.</p> <p>Facility staff has begun to have education on the Hand in Hand program provided by CMS which began on 3/14/14 and is ongoing. The facility has adopted this education as part of the Dementia training program and abuse prevention.</p> <p>At this time the facility supervisor's home base is the Brandon neighborhood. In addition, the Adopt a Neighborhood Nursing Administrative Nurse is stationed on the Brandon Neighborhood. Also, the Adopt a Neighborhood program continues to be an integral program providing additional staff throughout the day.</p> <p>The facility has implemented Consistent Neighborhood staffing on March 3, 2014 where staff are stationed on the same neighborhood</p> | |

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| F 223 | Continued From page 2 Per interview with the facility's Administrator and the Director of Nursing Services on 3/12/14 at 12:55 P.M., both confirmed, based upon the witnesses' statements, documents, interviews, and the facility's investigation of the incident, that Resident #1 was a victim of abuse at the facility by LNA #1 on 2/28/14. | F 223 | consistently to better understand the residents and their needs. | |
| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported | F 225 | The Hall Monitor program times were extended to encompass both the days and evening shifts respectively to provide greater observation of the neighborhood. The Director of Nursing or designee will audit the programming weekly to ensure that programming is being followed and that ongoing education is occurring as scheduled. The Administrator will conduct random audits of education and ensure compliance and will continue to ensure that all allegations are followed per the abuse policy. The facility has a zero tolerance policy on Abuse and will pursue discipline for any individual who is not cleared at the conclusion of the investigations. Data from the audits will be brought to the QAPI meeting every other month for six months or until the committee determines resolution. | |

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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 225 | <p>Continued From page 3</p> <p>to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source were reported immediately per regulation and facility policy for 1 of 3 residents [Resident #1]. Findings include:</p> <p>Per interview with the facility's Administrator and the Director of Nursing Services on 3/12/14 at 12:55 P.M., both confirmed, based upon witnesses' statements, documents, interviews, and the facility's investigation of the incident, that Resident #1 was a victim of abuse in the facility's dining room on 2/28/14.</p> <p>Per record review of the 3 witnesses' statements of the incident involving Resident #1, all 3 witnesses reported the incident occurred "at approximately 5:15 P.M." on 2/28/14. None of the 3 witnesses reported the event to their supervisor until 7:00 PM. Per interview on 3/11/14 at 4:16 P.M. with Resident #1's nurse from 2/28/14, Witness #1 came up to h/her "around 7:00 P.M...[H/she] brought [Resident #1] out of [h/her] room in a wheelchair, and told me [Resident #1] was upset, that [LNA #1] had upset [h/her]. [Witness #1] said it must be a</p> | F 225 | <p>The Administrator is ultimately responsible to ensure that Residents are free from abuse.</p> <p>The facility is filing an IDR for this deficiency</p> <p>Compliance Date: April 5, 2014</p> <p><i>F225 POI accepted 4/3/14 TDougherty RN/AMC</i></p> <p>F225 Investigate and Report allegation/individuals.</p> <p>The facility continues to conduct Background Checks, Registry Checks and Reference Checks for every employee upon hire and provides employees quarterly education on Abuse, Mistreatment and Neglect.</p> <p>LNA #1 was removed from resident care immediately and has been suspended pending the outcome of the investigation.</p> <p>All staff who worked on the Brandon Neighborhood on the evening shift of 2/28/14 are under investigation and discipline will be conducted as a result of the investigation. In addition, these staff members completed education on</p> | |

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| F 225 | <p>Continued From page 4</p> <p>continuation of [what happened in] the dining room. I asked [Witness #1] 'What do you mean by that?' [Witness #1] explained that [LNA #1] had told [Res. #1] to sit down, and grabbed [h/her] and put [h/her] in the chair." Resident #1's nurse stated "The other aide [Witness #2] then said 'if [Res. #1] has bruises, we'll know why'. Right away I knew this was something."</p> <p>Per interview with the facility's Administrator and the Director of Nursing Services on 3/12/14 at 12:55 P.M., both confirmed it was their expectation that the 3 witnesses, having been present during the incident, should have recognized it as abuse, and as mandated reporters, should have reported it to someone immediately, as per regulation and the facility's policy, but did not.</p> <p>Refer to F223.</p> | F 225 | <p>Abuse, Mistreatment and Neglect and signed an attestation form stating that they understand their reporting obligations.</p> <p>Facility staff has begun to have education on the Hand in Hand program provided by CMS which began on 3/14/14 and is ongoing. The facility has adopted this education as part of the Dementia training program and abuse prevention.</p> <p>Every neighborhood has administrative staffs' phone numbers in addition to Hotline numbers to report abuse. As part of the education staff is made aware of this avenue for reporting abuse.</p> <p>The facility has an Employee Assistance Program (EAP) to assist with personal stress and job "burnout". This program is available for all employees and has been educated as part of the "Hand in Hand" education. The numbers for this program are posted throughout the facility.</p> <p>The facility has a zero tolerance policy on Abuse and will pursue discipline for any individual who is not cleared at the conclusion of the</p> | | |

investigations and for any individual who does not report abuse immediately.

The Administrator or designee will review all allegation investigations and follow all staff members being investigated and will ensure discipline is conducted as warranted from the investigation process.

All reportable incidents are reviewed upon completion and data from the process is brought to the QAPI meeting every two months for review, this in an ongoing process that will be continued.

The Administrator is ultimately responsible to ensure that allegations of Abuse, Mistreatment and Neglect are reported per the Abuse Policy.

The facility is filing an IDR for this deficiency

Compliance Date: April 5, 2014

F205 POC accepted 4/3/14
TDouherthy RN/PMC