

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

June 29, 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 to the annual recertification survey conducted on **May 31, 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, MS
Licensing Chief

PC:ne

Enclosure



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

PRINTED: 06/15/2012
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 05/31/2012
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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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(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 follow-up survey to the annual recertification survey was conducted on 5/29/12 - 5/31/12 by the Division of Licensing and Protection. The facility was found to be in substantial compliance with all F-Tag citations cited during the annual recertification survey with the exception of F241 which is cited for additional findings.	{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 241} SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to promote care that maintains dignity related to repeated episodes of incontinence for one resident (Resident #1) of the sample group. Findings include: 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, Post Traumatic Stress Disorder, and is confined to a wheel chair, was scheduled to be transported to the Albany Veteran Affairs Hospital on 4/26/12 for a doctor's appointment. Per interview on 5/29/12 at 1:35 P.M. with the Veteran Care Assistant (VCA), on 4/26/12 the nurse on Resident #1's unit told the VCA that h/she would	{F 241}	F241 <u>Corrective Action:</u> Effective immediately, Resident #1 is to be accompanied by staff able to assist Resident #1 with care needs anticipated while out on pass. <u>Other residents:</u> All Residents requiring assistance with care needs attending outside appointments are at risk. <u>Systemic Changes:</u> All nursing staff and transport staff educated on revised policy and procedure for residents out on pass, transports and criteria for level of assist while out on pass. Education to all nurses and those setting up arrangements for transport regarding criteria for determining appropriate staff to accompany resident and nurses regarding obtaining and documenting medications while resident is out on pass.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Melissa A Jackson, BSW, LHA *Administrator* *6/21/12*

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 241}	<p>Continued From page 1</p> <p>be accompanying Resident #1 on transport to the Hospital. During the transport Resident #1 needed to urinate but was unable to hold the urinal. The VCA stated h/he had to hold the urinal while Res. #1 voided. The VCA stated h/she was never trained to assist with this.</p> <p>Later at the Hospital, Res. #1 again had to void. The VCA stated they had to go into a Men's Room where there were other people present and again assisted Res. #1 with voiding. The VCA stated Res. #1 told h/her "this is not right". Per record review, Resident #1's Care Plan, marked reviewed on 3/9/12 - Res. #1 'has a self care deficit...frequently incontinent of urine...Approaches: Incontinent care as needed and toileted as [Res. #1] requests. [Res. #1] wears an incontinent product for dignity'. Per record review of the Bladder Incontinence Evaluation 12/8/11 'daily incontinence episodes'...Functional status: 'extensive assist'...Contributing factors: 'congestive heart failure, depression, dementia, obesity, paranoid delusions, degenerative joint disease, tremors, post traumatic stress disorder'. Medication regimen: 'diuretics, sedative/hypnotics, narcotics, antipsychotics, antidepressants'.</p> <p>Per interview with staff RN #2 on 5/30/12 at 11:11 A.M. Resident #1 "is total care. [H/she] will call when [h/she] needs to void but [h/she] needs assistance". Per record review Occupational Therapy (OT) Progress Report 3/21/12 indicates Res. #1 needs extensive assist with toileting. OT Progress notes dated 4/3/12 state 'current status [urinal]: spills 4 out of 5 attempts'.</p> <p>Per record review on 5/30/12 of written</p>	{F 241}	<p><u>Monitoring:</u> Members of the IDT team will inquire with residents transported to outside appointments that their needs were anticipated and met by the appropriate staff and whether the experience was positive, areas requiring improvement. IDT will review 20% of all transports, x 90 days, to assure that level of required resident assistance was met and to assure compliance with current policy and procedures for transports. Audit results to be reviewed at bimonthly QA meetings.</p> <p><u>Compliance Date:</u> June 27, 2012</p> <p><i>F241 POC accepted 6/28/12 mtgqmsrn / Pmc</i></p>	
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{F 241}	<p>Continued From page 2</p> <p>statements in the facility's investigation of the incident, reported on 5/3/12, the Director of Nursing Services (DNS), the Assistant Director of Nursing Services (ADNS), the Clinical Care Coordinator of Resident #1's unit (CCC), and the unit's Registered Nurse (RN) were aware that the VCA was to accompany Resident #1 on the transport.</p> <p>Per record review on 5/30/12: Vermont Veteran's Home Job Description-Veteran Care Assistant (VCA): 'A Veteran Care Assistant may not do any patient care.' Per record review of the Administrator's (ADM) interview of the VCA during the facility investigation: on 4/26/12, prior to the transport "there was no conversation about what [the VCA] should do if [Res. #1] needed to go to the bathroom". Per interview with Resident #1 on 5/30/12 at 2:23 P.M. the resident described h/her feelings during the 4/26/12 incident as "undignified".</p> <p>Per interview with the facility's ADM on 5/31/12 at 2:30 P.M. the ADM confirmed Res. #1 had a history of daily incontinence and was care planned and assessed as needing extensive assistance with toileting. The ADM confirmed that the resident was knowingly sent with a staff member who, per facility policy, could not assist with toileting or incontinence care, and was assisted with both by the female VCA in a Men's Room with other people present. The ADM stated that a VCA had accompanied Resident #1 on other transports and there had never been any issues.</p> <p>2. Per interview with a Staff Supervisor on 5/30/12 at 11:57 A.M. Resident #1 had an appointment in Troy, NY on 5/14/12. The resident</p>	{F 241}		
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{F 241}	<p>Continued From page 3</p> <p>was set up to be transported alone in h/her wheelchair. The Supervisor stated h/she spoke with the DNS who said the unit's nurse did not have to go with the resident. The Supervisor reported this to the ADM and stated to h/her that the ADM had said after the incident on 4/26/12 Resident #1 would never leave the facility again without a nurse. The Supervisor reported Resident #1 was sent alone to the appointment on 5/14/12.</p> <p>Per record review of Nursing Notes dated 5/14/12 "Vet left for [MD] appointment in Troy, NY. Vet toileted and brief in place prior to leaving. Urinal with veteran". An additional Nursing Note dated 5/14/12 states "[MD]'s office called. Vet incontinent of urine there. Office asked why no LNA [Licensed Nursing Assistant] or extra brief sent with [h/her]".</p> <p>Per interview with staff RN #2 on 5/30/12 at 11:11 A.M. Resident #1 "is total care. [H/she] will call when [h/she] needs to void but [h/she] needs assistance". Per record review, an Occupational Therapy (OT) Progress Report dated 3/21/12, Res. #1 required extensive assist with toileting. OT Progress notes dated 4/3/12 state 'current status [urinal]: spills 4 out of 5 attempts'.</p> <p>Per interview with Resident #1 on 5/30/12 at 2:23 P.M. h/she was transported alone to the appointment. The resident reported h/she was in a brief and given a urinal but was incontinent of urine on h/her clothes and in the transport van, and again in the doctor's office. Resident #1 stated h/she was in the wet brief for approximately 3 ½ hours and the brief was not changed until h/she returned to the facility. The resident stated "the urine burns my skin" and the</p>	{F 241}		
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{F 241}	<p>Continued From page 4</p> <p>incident was "demeaning". Per interview with a Staff Supervisor on 5/30/12 at 11:57 A.M. Resident #1's sister had met the resident at the doctor's office. Afterwards, the sister had spoken to the ADM and was very upset that she had to take care of [Res. #1]'s urinating on the floor in the doctor's office.</p> <p>Per interview with the facility's ADM on 5/31/12 at 2:30 P.M. the ADM confirmed Res. #1 had a history of daily incontinence and was care planned and assessed as needing extensive assistance with toileting. The ADM also confirmed that the resident, after being incontinent on the previous trip, was sent without any assistance on 5/14/12 and was again incontinent and had to wait until h/her return to the facility before receiving help.</p>	{F 241}		
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