

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 revisit survey to a complaint investigation 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

RECEIVED
Division of PRINTED: 06/15/2012
JUN 25 12 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 _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED R-C 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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F 000	INITIAL COMMENTS An unannounced follow-up survey to a complaint investigation was conducted on 5/29/12 - 5/31/12 by the Division of Licensing and Protection. There are additional findings cited for F282.	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 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 observation, interview, and record review, the facility failed to provide services by qualified persons for one resident (Resident #1) when arranging for medications to be given during transport, and failed to implement the resident's plan of care by failing to give 9 medications as ordered. 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 be accompanying Resident #1 on transport to the Hospital.	{F 282}	F282 <u>Corrective Action:</u> Resident #1 will be accompanied by a licensed nurse to appointments that require medications during the appointment times that cannot be given at alternate times. Nurse educated on correct documentation of medications while residents are out on pass and to notify Provider for further instruction if medications will not be able to be administered or delayed related to unforeseen circumstances while residents are out on pass. <u>Other Residents:</u> All Residents going out on pass with medications 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	

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

Amc

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{F 282}	<p>Continued From page 1</p> <p>Per record review of facility Policy 'Administering Medications' the policy includes "only persons licensed or permitted by this State to prepare, administer, and document the administration of medications may do so". Per record review, Vermont Veteran's Home Job Description-Veteran Care Assistant (VCA): The VCA assists Veterans/Members by performing duties that do not require a license to perform. During the interview on 5/31/12 the ADM and DNS stated that because of Resident #1's Parkinson tremors, the VCA accompanying him was instructed by the Clinical Care Coordinator "only to hold [h/her] hand to steady it" while Resident #1 took the medications. The ADM and DNS stated that the VCA "had taken it upon herself" to administer the medication. Per observation on 5/30/12 at 11:00 A.M. Resident #1 received his oral medications on a spoon in applesauce, administered by a staff LPN. The resident did not assist in the administration. Per interview with Resident #1 on 5/30/12 at 2:23 P.M. when asked how the resident receives h/her medications, the resident stated "they put a spoon in my mouth".</p> <p>Per interview on 5/31/12 at 2:30 P.M. the ADM and DNS confirmed that instructing the VCA to assist Resident #1 in getting the medication into h/her mouth was equivalent to the VCA administering the medication, and that the VCA was not licensed to administer medications. Per record review of the facility's investigation of the incident, reported on 5/3/12, written statements by staff RN, Assistant Director of Nursing Services (ADNS), and the Clinical Care Coordinator of Resident #1's unit "discussed the</p>	{F 282}	<p>medications while resident is out on pass.</p> <p><u>Monitoring:</u> IDT will review 100% of records where resident required medications while on transport to assure appropriate personnel and documentation in place x 90 days. IDT will review 20% of all other transports 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>F282 POC accepted 6/28/12 M Higgins RN / fmc</i></p>	
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{F 282}	<p>Continued From page 2</p> <p>nurse could prepare his medication and the VCA could hand [Res.#1] a spoon". The statement continues "[Res. #1] would retrieve the medication from the med cup and medicate [h/her self]".</p> <p>Per record review of facility policy: 'Self Administration of Medications', nursing is to use the form "Assessment for Self-Administration of Medications Ability", the Care Plan Team is to review the completed form, the resident is to be evaluated for safety and compliance, and a note is to put on the MAR 'Resident self-medicating.' Per interview with Resident #1 on 5/30/12 at 1:30 P.M. stated s/he had asked Nursing previously if s/he could self-administer medications and "they said 'no'". Per interview with the ADM, the DNS, the AADM and ADNS on 5/31/12 at 2:30 P.M. confirmed Resident #1 was never assessed for self-administration of medications, and there was no documentation on the MAR indicating h/she could. The ADM and DNS also confirmed that Resident #1 was not qualified to self-administer medications per facility policy, and that Supervisory staff discussed and agreed to send Resident #1 on transport to do so.</p> <p>2. 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 for Mood, Behavior, and Psychosocial Wellbeing that includes: 'administer medications as ordered by provider'. Per record review of Resident #1's Medication Administration Record (MAR) for April 2012, Resident #1 is ordered daily</p>	{F 282}		
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{F 282}	<p>Continued From page 3</p> <p>doses of the following medications due at 4:00 P.M.: Diazepam (anti-anxiety medication), Metoprolol (cardiac medication), Seroquel (anti-psychotic medication), Carbamazepine (an anticonvulsant and mood stabilizer), Bisacodyl (a laxative), Calcium Antacid, Potassium, Vitamin D, a stool softener, along with Sinemet (used to treat Parkinson's disease) which is scheduled to be given at 1:30 P.M., 4:00 P.M., and 6:30 P.M.</p> <p>Per record review of Nursing Notes for 4/26/12, Resident #1 was transported to a doctor's appointment at the Albany Veterans Affairs Hospital. Resident #1 missed h/her scheduled appointment, was seen later by the doctor, and did not return to the facility until 5:45 P.M. Because of the extended length of the trip, The facility obtained an order for the Sinemet, due at 4:00 P.M., to be administered by the Hospital. Per record review of the Medication Administration Record for Resident #1 on 4/26/12, the dose of Sinemet due at 4:00 P.M. was signed as given by 'AVA' (Albany Veterans Hospital).</p> <p>Per record review Nursing Notes 4/26/12 5:50 P.M. "Veteran did not receive Sinemet at AVA ER per order of [Nurse Practioner]." Per record review of Physician's Orders on 4/26/12, at 5:50 P.M. an order was obtained to administer the 6:30 P.M. dose of Sinemet at the present time.</p> <p>Per interview with the facility's DNS and ADM on 5/31/12 at 2:30 P.M. the DNS confirmed that the 4:00 P.M. Sinemet dose signed as given was not, and the nurse who signed out the medications "should have written a note" but did not. The DNS and ADM confirmed that a total of 9 medications</p>	{F 282}		
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{F 282}	Continued From page 4 due to be given to Resident #1 at 4:00 P.M. were not, that an order should have been obtained to administer the missed medications, and that there was no documentation any attempt had been made. The ADM confirmed this was against facility policy and that the Care Plan for Resident #1 called for "administer medications as ordered" and they were not.	{F 282}		
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