

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

July 6, 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 survey and 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

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 C 05/31/2012
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	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 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to determine if one resident (Resident #1) could safely self administer medications prior to arranging for the resident to do so. 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 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 nurse could prepare [h/her] medication and the VCA [Veterans Care Assistant] could hand [Res.#1] a spoon". The	F 176	F176 <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 medications while attending outside appointments are at risk. <u>Systemic Changes:</u> All residents who are to self administer medications while out on pass will have a self administration assessment performed and documented. All nursing staff and transport staff educated on the policy and procedure for residents who can self administer medications while 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 Melissa A Jackson BSW LNHA TITLE Administrator (X6) DATE 6/2/12

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.

PM

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F 176	Continued From page 1 statement continues "[Res. #1] would retrieve the medication from the med cup and medicate [h/her self]". Per record review of the 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 on the MAR [Medication Administration Record] to state '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 Administrator (ADM), the Director of Nursing Services (DNS), the Assistant ADM and Assistant DNS 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.	F 176	<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. Audit results to be reviewed at bimonthly QA meeting. <u>Compliance Date:</u> June 27, 2012 <i>File POC accepted 6/29/12 TDougherty RN J AML</i>		
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	F 241			

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F 241	<p>Continued From page 2</p> <p>maintains dignity related to repeated episodes of incontinence for one resident (Resident #1) of the sample group. Findings include:</p> <p>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. 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</p>	F 241	<p>F241</p> <p><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.</p> <p><u>Other residents:</u> All Residents requiring assistance with care needs attending outside appointments are at risk.</p> <p><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.</p> <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</p>	

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F 241	<p>Continued From page 3</p> <p>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 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</p>	F 241	<p>results to be reviewed at bimonthly QA meeting.</p> <p><u>Compliance Date:</u> June 27, 2012</p> <p><i>F241 POC accepted 6/29/12 TDougherty RN / Pincot RN</i></p>	

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F 241	<p>Continued From page 4</p> <p>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 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</p>	F 241			

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F 241	Continued From page 5 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'. 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 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. 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.	F 241			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281			

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F 281	<p>Continued From page 6 must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide or arrange services that meet professional standards for one resident (Resident #1) by delegating nursing tasks to an unlicensed aide, arranging for self-medication for an unqualified resident, signing for a medication that was not given, and failing to give 9 medications as ordered. Findings include:</p> <p>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.</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</p>	F 281	<p>F281 <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.</p> <p><u>Other Residents:</u> All Residents going out on pass with medications are at risk.</p> <p><u>Systemic Changes:</u> Only Residents with documented ability to self-administer medications per facility policy will be able to self-administer medications while out on pass. 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.</p>		

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F 281	<p>Continued From page 7</p> <p>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 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</p>	F 281	<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. Audit results will be reviewed at bimonthly QA meetings.</p> <p><u>Compliance Date:</u> June 27, 2012</p> <p><i>F281 POC accepted 6/29/12 TOaugherty RN / AMC</i></p>	

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F 281	<p>Continued From page 8</p> <p>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>Per record review on 6/4/12 'Vermont State Board of Nursing-The Role of the Nurse in Delegating Nursing Interventions Position Statement-Delegation: Transferring to a competent individual the authority to perform selected nursing tasks in a selected situation. Background: The RN and LPN delegate tasks based on the needs and condition of the patient, potential for harm, stability of the patients condition, complexity of the task, predictability of the outcomes, and the abilities of the staff to whom the task is delegated.' (1)</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</p>	F 281		
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F 281	<p>Continued From page 9</p> <p>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 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</p>	F 281			

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F 281	Continued From page 10 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 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. 1) http://www.vtprofessionals.org/opr1/nurses/position_statements/	F 281	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> Only Residents with documented ability to self-administer medications per facility policy will be able to self-administer medications while out on pass. 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.		
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,	F 282			

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F 282	<p>Continued From page 11</p> <p>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.</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>	F 282	<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. Audit results to be reviewed at bimonthly QA meeting</p> <p><u>Compliance Date:</u> June 27, 2012</p> <p><i>F282 POC accepted 6/29/12 TDougherty RN/PMC</i></p>		

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F 282	<p>Continued From page 12</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 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>	F 282			

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F 282	<p>Continued From page 13</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 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</p>	F 282		
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F 282	Continued From page 14 per order of [Nurse Practitioner]." 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. 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 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	F490 <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 and accompanied by an LNA to appointments if s/he does not require medications. 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 and assistance with care needs are at risk.	
F 490 SS=G	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility is not administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. (Resident #1) Findings include:	F 490	<u>Systemic Changes:</u> Only Residents with documented ability to self-administer medications per facility policy will be able to self-administer medications while out on pass. 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.	

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F 490	Continued From page 15 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. 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. 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	F 490	<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. 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 to assure that level of required resident assistance was met and to assure compliance with current policy and procedures for transports. Audit results will be reviewed at bimonthly QA meetings. <u>Compliance Date:</u> June 27, 2012 <i>F490 POC accepted 6/29/12 TDougherty RN / PML</i>		

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F 490	<p>Continued From page 16</p> <p>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 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</p>	F 490		

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F 490	<p>Continued From page 17</p> <p>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 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.</p>	F 490			

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F 490	<p>Continued From page 18</p> <p>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 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> <p>3. 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</p>	F 490		

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F 490	<p>Continued From page 19</p> <p>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.</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</p>	F 490			

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 C 05/31/2012
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F 490	<p>Continued From page 20</p> <p>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 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>Per record review on 6/4/12 'Vermont State Board of Nursing-The Role of the Nurse in Delegating Nursing Interventions Position</p>	F 490			

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F 490	<p>Continued From page 21</p> <p>Statement-Delegation: Transferring to a competent individual the authority to perform selected nursing tasks in a selected situation. Background: The RN and LPN delegate tasks based on the needs and condition of the patient, potential for harm, stability of the patients condition, complexity of the task, predictability of the outcomes, and the abilities of the staff to whom the task is delegated.' (1)</p> <p>4. 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 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</p>	F 490		
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F 490	<p>Continued From page 22</p> <p>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 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.</p>	F 490			