



State of Vermont
Vermont Veterans' Home
323 North Street
Bennington, VT 05201

(phone) 802-442-6353
(fax) 802-447-2757

September 22, 2012

Mr. Richard Shaw, Branch Chief
Certificate & Enforcements Branch
Northeast Consortium Division of Survey & Certification
Centers for Medicare and Medicaid Services
JFK Federal Building, Room 2275
Government Center
Boston, MA 02203

Attn: Enforcement Unit

Dear Mr. Shaw:

Enclosed you will find The Vermont Veterans' Home's plan of correction for the September 13, 2012 complaint survey.

Please do not hesitate to contact me if you should require additional information. I can be reached at 802-447-6533 or Melissa.jackson@state.vt.us

Sincerely,

Melissa A. Jackson, BSW, LNA
Administrator



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

PRINTED: 09/18/2012
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 09/13/2012
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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	F 000		
F 223 SS-J	<p>An unannounced, on site, complaint investigation was completed on 09/13/12 by the Division of Licensing and Protection. The following deficiencies were issued as a result.</p> <p>483.13(b); 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, observations, review of the Abuse Prevention Policy and review of behavior/intervention monthly flow records, the facility failed to prevent staff to resident physical abuse, resulting in immediate jeopardy when one Resident (#1) was struck in the face by a staff nurse and sustained bilateral nasal bone fractures.</p> <p>The Director of Nursing, Assistant Director of Nursing, Administrator and Assistant Administrator were notified on 09/13/12 at 4:15 P.M. that Immediate Jeopardy began on 09/11/12 at 7:05 P.M. when Licensed Practical Nurse (LPN) #5 struck Resident #1 in the face. Resident #1 was treated in the emergency room on 09/11/12 and sustained bilateral nasal bone fractures</p>	F 223	<p>The Veterans' Home is committed to the safety and security of all its residents. While we reserve the right to request an IDR or to file an appeal we submit this plan of correction in accordance with specific regulatory requirements to insure resident remain free from abuse/involuntary seclusion.</p> <p>F 223</p> <p>Resident #1 was struck in the face by a staff member. We took the following actions immediately: 1) Nurse #5 self-reported this incident 2) Nurse #5 was removed from the building immediately and placed on administrative leave 3) local law enforcement authorities were notified 4) Resident #1 was sent to the emergency room for evaluation. A root cause analysis was conducted for Resident #1 and the findings are outline below.</p> <p>Resident #1 was evaluated by an ENT on 9/14/12. The ENT determined that there are no nasal fractures present the resident does have a chronic deformity of the nasal septum as a result of reconstructive surgery</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Missie A Jackson BSW, RNHA* TITLE: *Administrator* (X6) DATE: *9/21/12*

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 that 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47503Z	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/13/2012
NAME OF PROVIDER OR SUPPLIER VERMONT VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 328 NORTH STREET BENNINGTON, VT 05201	
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F 223	<p>Continued From page 1</p> <p>Review of an Event Reporting Form submitted to the Division of Licensing and Protection by the Director of Nursing on September 13 revealed that LPN # 5 reported to a Nursing Supervisor that LPN # 5 struck Resident # 1 in the face on September 11, 2012. Review of a September 11, 2012 Physician Communication note signed by a facility RN reveals a notation that Resident # 1 was punched in the nose by staff.</p> <p>Review of the record for Resident #1 on 09/13/12, revealed an admission date of 12/19/11 and diagnoses of depression, recent facial herpes zoster, recent suicidal ideation, squamous cell carcinoma of the face with radiation and reconstructive surgery, right molar facial mass, and diabetes. The most recent Minimum Data Set Assessment (MDS) dated 09/04/12, indicates Resident #1 has moderately impaired cognitive function with no short or long term memory problems. The mood severity score is seven and indicates Resident #1 reports daily hopelessness, is short tempered, and had one recent expression of the desire to inflict self harm. The MDS indicates care is rejected 4-6 of 7 days. Resident #1 requires limited assistance (non weight bearing) of one staff for bed mobility, transfer, locomotion off the unit, dressing, personal hygiene and bathing. Resident #1 is independent with eating, toileting, and locomotion on the unit.</p> <p>The plan of care for behavioral symptoms, dated 05/11/12, indicates Resident #1 has behavioral symptoms related to being verbally abusive to staff and other residents, and can be resistive to care being offered. On 08/20/12 an additional notation was made of suicidal ideation related to</p>	F 223	<p>after removal of Squamous Cell CA of the face. The resident denies pain at this time and behaviors are currently improved with recent changes to the behavior care plan. Care plan interventions include two care givers at all times, always approach resident from the front in a calm manner, do not lean over the resident to snuff off call light, a discussion was conducted with the resident to change his room configuration so that staff do not have to lean over him and invade his personal space, if agitation is noted leave the resident and re-approach at a later time.</p> <p>As a result of the root cause analysis the following changes to our systems will be implemented: Facility leadership met with staff on all shifts to inquire as to what happened with Resident #1 and to determine what can be done to prevent this in the future. These suggestions were added to Resident's #1 care plan. All residents with behaviors that are noted to cause stress to staff and are difficult to alter have been identified. These resident's behaviors and interventions that are</p>	

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F 223	<p>Continued From page 2</p> <p>pain and on 09/12/12 a notation of physical abuse towards others. An undated notation indicates Resident #1 has ongoing behaviors such as throwing items at staff and foul language as evidenced by nurses notes on 04/10/12 and previous. The goal stated for Resident #1 indicates the resident should have improved or maintain acceptable behavior through next review. The interventions include 1) Assess, monitor and document unacceptable behaviors. Observe what may trigger these behaviors, document and notify the MD. 2) Intervene to ensure the safety of the Resident and others, encourage to ask for assistance and ring the call light. 3) Visual checks only at night - do not wake up - per Resident request. 4) Anticipate the needs of the resident before the resident becomes overly stressed. Approach calmly. 5) Provide 1:1 time for resident to express feelings and concerns. 6) Maximize strengths and positive behaviors. Offer meals in room with increased behaviors. 7) Administer medications as ordered. Observe for effectiveness and side effects. The Licensed Nurse Aid (LNA) assignment sheet updated 09/12/12 was reviewed and indicated Resident #1 required 1 assistance when in bed, was independent in the wheelchair, required 1 assistance with toileting and special instructions indicated the Resident took Ensure with meals. A physician's order dated 08/23/12 discontinued multiple medications, including an antidepressant. The corresponding progress note indicated the Resident had been refusing medication for greater than one week and requested all medication be stopped. The medication administration record indicated Resident #1 did not receive medication on one day, 08/23/12.</p>	F 223	<p>effective in altering the behaviors have been identified and the care plans revised or rewritten to include these effective interventions. In addition, those identified residents' are rotated on the LNAs assignments to ensure that staff burnout and stress are alleviated. The systems changes will ensure that this will not reoccur with Resident #1 or any other Resident.</p> <p>Facility leadership have completed an audit of all employees to ensure that every employee has had the proper background checks, registry checks and reference checks prior to hire. In addition, education on the abuse policy has been educated to staff. This education began on Tuesday September 11, 2012 and will be ongoing.</p> <p>Facility leadership is conducting staff meetings. Those meetings will have a discussion about staff stress and inform them of ways to alleviate stress and to also inform them of programs available to them for counseling etc. Staff is encouraged to schedule a face to face meeting for any stress they may have. Facility leadership will direct them to the</p>	

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F 223	<p>Continued From page 3</p> <p>The reason was not documented.</p> <p>Review of the behavior/intervention monthly flow record for 08/2012 revealed that agitation/irritability as evidenced by verbal abuse was documented on day shift on 08/10/12 and positive results were noted from redirection and reapproach. On 08/29/12 no results were noted from redirection, 1:1, return to room, or position change when attempted. The record for 09/2012 revealed that agitation, as evidenced by verbal abuse, was displayed on 09/01/12, 09/02/12 and 09/03/12. Interventions included redirect, 1:1 and re approach and were effective only on 09/03/12. No behaviors were documented on 09/11/12. Review of the nurses notes for 09/2012 revealed no documented behaviors for 09/2012 and the documentation on 09/11/12 specifically, did not indicate behaviors. A care plan meeting note was made on 09/11/12 and was untimed. It indicated Resident #1 did not attend and the same plan of care was to continue.</p> <p>Review of Situation, Background, Assessment, Request (SBAR) form dated 09/11/12 revealed that on 09/11/12 at 7:10 P.M., Resident #1 was "punched in the nose by staff" LPN #5. The attached progress note indicated that the Registered Nurse supervisor was called to the American Way unit at 7:10 P.M. on 09/11/12, when Resident #1 reported being hit in the nose by staff. Staff reported Resident #1 had been agitated, calling them names and throwing things through out the evening. Resident #1 initially declined to go to the Emergency Room but later agreed. Resident #1 was transferred with police escort at 7:50 P.M. The Emergency Room</p>	F 223	<p>appropriate support services.</p> <p>All residents identified with behaviors that are difficult to alter will have visits by the Social Worker twice a month to discuss the behaviors and interventions that would alter the behaviors. The care plans will be revised as warranted from these visits and referrals made to psychological services as necessary.</p> <p>The Director of Social Services will conduct an audit every two weeks on residents with noted behaviors to ensure weekly visits by the Social Worker are occurring. The Director of Nursing Services or designee will conduct audits to ensure that the physician is notified of issues as warranted and the plan of care is revised to reflect their current status.</p> <p>The Administrator or designee will conduct audits of newly hired staff to ensure all background checks have been conducted as well as registry checks and reference checks.</p>	

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F 223	<p>Continued From page 4</p> <p>Department Report indicated Resident #1 arrived with dried blood in the right nares and mild bilateral tenderness to palpation. CT scan revealed mildly displaced bilateral nasal bone fractures. The report indicates Resident #1 had a known history of deeply invasive squamous cell carcinoma of the right face. The nurses note dated 09/12/12 at 3:00 A.M., indicated Resident #1 returned to the facility on 09/12/12 at 2:30 A.M. with diagnoses of nasal fracture, nasal contusion, and abrasion. The documentation indicated Resident #1 asked on return "Is that man here?, the one who hit me?" The nurse documented reassurance and observation of slight swelling to the nose. Review of the facility investigation revealed that all staff on the unit documented statements and all staff indicated Resident #1 had been agitated through out the evening, beginning in the dining room at the evening meal, calling them vulgar names, cursing and throwing water bottles at them. No one witnessed the incident.</p> <p>Observation of Resident #1 on 09/13/12 at 11:05 A.M. revealed an abrasion, slight swelling and redness to the tip of the nose and dried blood visible in the nares. The nose deviates slightly to the left. During interview at this time, Resident #1 stated "of course it hurts". LPN #5 "hit me for no reason". Resident #1 stated that the nasal fracture is painful. Resident #1 refused further comment.</p> <p>Interview of the RN caring for Resident #1 on 09/13/12 at 11:50 A.M. revealed that Resident #1 "has never been very nice, but has had increased behaviors lately". When asked to elaborate the RN stated "since the</p>	F 223	<p>Data from the audits will be brought to the Quality Assurance meeting bi-monthly for six months or until the committee has determined resolution.</p> <p>The Administrator is ultimately responsible to ensure that residents are free from abuse.</p> <p>Completion Date: September 25, 2012</p>	

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F 223	<p>Continued From page 5</p> <p>antidepressant was discontinued. I think for refusal, but [Resident #1] always takes medications for me". The RN indicated that Resident #1 displayed verbally abusive behaviors but denied knowledge of any physical behaviors. Interview of the LNA who cared for Resident #1 on 09/11/12 revealed that on that date many different people were in and out of Resident #1's room. The LNA indicated that Resident #1 had daily verbal outbursts and they were worse on this date. The LNA indicated behaviors were typical and that the assignment sheet did not address Resident #1's behaviors. The LNA stated "we had nothing to go by" then. The LNA indicated that now there are "steps to follow" to manage the behaviors and try to keep them from getting that bad</p> <p>Interview of the Social Worker for American Way unit and the Social Worker from unit D, where Resident #1 resided prior to a room change late in June, on 09/13/12 at 4:00 P.M., revealed that Resident #1 had always displayed verbal behaviors. They stated that after the move, the end of June, Resident #1's behaviors improved and recently started to return to previous patterns. They stated the Resident's pattern was to be distant until suddenly, rapidly escalating to an explosive episode. They indicated the Resident is difficult to support without overwhelming. During review of the plan of care at that time, both confirmed that there were no specific interventions listed to manage Resident #1's behaviors and stated that is why the Plan of Action in case of escalating behavior was developed on 09/12/12. They stated that staff were being in-serviced on the plan of action but that was ongoing, at shift change each day and</p>	F 223		

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F 223	<p>Continued From page 6</p> <p>all staff had not been in-service. Both reviewed the behavior/intervention flow records for 08/2012 and 09/2012 and verified that daily behaviors were reported by staff but not documented and reported they were unaware of increased behaviors until the 09/11/12 incident. They reported that Resident #1 scored a 13 of 13 on the geriatric depression scale on 09/13/12, indicating severe depression and 21 of 30 on the mini mental status exam completed on 09/13/12, indicating moderately impaired cognitive function. The Social Worker from unit D reported that Resident #1 had asked during interview, if the nurse was still there and Resident #1 indicated to the Social worker that s/he was afraid someone might try to kill him/her.</p> <p>interview of the DNS and Administrator on 09/13/12 at 4:15 P.M. confirmed that daily behaviors were reported by staff during the investigation but were not consistently documented per the plan of care. The DNS stated we have identified that and are in the process addressing it. They confirmed that the LNA assignment sheet did not reflect current information about the behaviors of Resident #1 and did not reflect the updates made on 09/12/12 to provide 2 staff with care.</p>	F 223	<p>F 279</p> <p>Resident #1 was struck in the face by a staff member. We took the following actions immediately: 1) Nurse #5 self-reported this incident 2) Nurse #5 was removed from the building immediately and placed on administrative leave 3) local law enforcement authorities were notified 4) Resident #1 was sent to the emergency room for evaluation. A root cause analysis was conducted for Resident #1 and the findings are outline below.</p> <p>Resident #1 was evaluated by an ENT on 9/14/12. The ENT determined that there are no nasal fractures present the resident does have a chronic deformity of the nasal septum as a result of reconstructive surgery after removal of Squamous Cell CA of the face. The resident denies pain at this time and behaviors are currently improved with recent changes to the behavior care plan. Care plan interventions include two care givers at all times, always approach resident from the front in a calm manner, do not lean over the resident to shut off call light, a discussion was</p>	
F 279 SS-D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's</p>	F 279		

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F 279	<p>Continued From page 7</p> <p>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to develop a comprehensive plan of care which accurately reflected the behavioral history and provided direction for the management of current behaviors for Resident #1. This affected one (Resident #1) resident in the applicable sample. Findings include:</p> <p>Review of the record for Resident #1 on 09/13/12, revealed an admission date of 12/19/11 and diagnoses of depression, recent suicidal ideation. The most recent Minimum Data Set Assessment (MDS) dated 09/04/12, indicates Resident #1 has moderately impaired cognitive function with no short or long term memory problems. The mood severity score is seven and indicates Resident #1 reports daily hopelessness, is short tempered, and had recently expressed a desire to inflict self harm. The MDS indicates care is rejected 4-6 of 7</p>	F 279	<p>conducted with the resident to change his room configuration so that staff do not have to lean over him and invade his personal space, if agitation is noted leave the resident and re-approach at a later time.</p> <p>As a result of the root cause analysis the following changes to our systems will be implemented: Facility leadership met with staff on all shifts to enquire as to what happened with Resident # 1 and to determine what can be done to prevent this in the future. These suggestions were added to Resident #1's care plan. All residents identified with behaviors that are difficult to alter will have visits by the Social Worker twice a month to discuss the behaviors and interventions that would alter the behaviors. The care plans will be revised as warranted from these visits and referrals made to psychological services as necessary.</p> <p>Nursing staff have had education started on September 11, 2012 regarding rousing and following the plan of care this education will be ongoing.</p> <p>The Director of Social Services will conduct an</p>	

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F 279 Continued From page 8
days. Resident #1 requires limited assistance (non weight bearing) of one staff for bed mobility, transfer, locomotion off the unit, dressing, personal hygiene and bathing. Resident #1 is independent with eating, toileting, and locomotion on the unit.

The plan of care for behavioral symptoms, dated 05/11/12, indicates Resident #1 has behavioral symptoms related to being verbally abusive to staff and other residents, and can be resistive to care being offered. On 08/28/12 an additional notation was made of suicidal ideation related to pain and on 09/12/12 a notation of physical abuse towards others. An undated notation indicates Resident #1 has ongoing behaviors such as throwing items at staff and foul language as evidenced by nurses notes on 04/10/12 and previous. The goal stated for Resident #1 indicates the resident should have improved or maintain acceptable behavior through next review. The interventions include 1) Assess, monitor and document unacceptable behaviors. Observe what may trigger these behaviors, document and notify the MD. 2) Intervene to ensure the safety of the Resident and others, encourage to ask for assistance and ring the call light. 3) Visual checks only at night - do not wake up - per Resident request 4) Anticipate the needs of the resident before the resident becomes overly stressed. Approach calmly. 5) Provide 1:1 time for resident to express feelings and concerns. 6) Maximize strengths and positive behaviors. Offer meals in room with increased behaviors. 7) Administer medications as ordered. Observe for effectiveness and side effects. The plan of care did not indicate that Resident #1 refused psychological counseling or

F 279 audit every two weeks on residents with noted behaviors to ensure weekly visits by the Social Worker are occurring. The Director of Nursing Services or designee will conduct audits to ensure that the physician is notified of issues as warranted and the plan of care is revised to reflect their current status.

Data from the audits will be brought to the Quality Assurance meeting bi-monthly for six months or until the committee has determined resolution.

The Director of Nursing Services is ultimately responsible to ensure that care plans are developed and reflect the resident's status.

Completion Date:
September 25, 2012

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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 279	<p>Continued From page 9</p> <p>that antidepressant medication had been discontinued at the Resident's request. There was no specific information regarding likes or dislikes to distract or redirect the Resident or what triggered behaviors in the past.</p> <p>Interview of the RN caring for Resident #1 on 09/13/12 at 11:50 A.M. revealed that Resident #1 "has never been very nice, but has had increased behaviors lately". When asked to elaborate the RN stated "since the antidepressant was discontinued, I think for refusal, but [Resident #1] always takes medications for me". The RN indicated that Resident #1 displayed verbally abusive behaviors but denied knowledge of any physical behaviors. When asked how staff managed the behaviors Resident #1 displayed, the RN stated "just go back later is all we can do". Interview of the LNA who cared for Resident #1 on 09/11/12 revealed that, on that date, many different people were in and out of Resident #1's room. The LNA indicated that Resident #1 had daily verbal outbursts and they were worse on this date. The LNA indicated behaviors were typical and that the assignment sheet did not indicate how to address Resident #1's behaviors. The LNA stated "we had nothing to go by" then. The LNA indicated that "now there are steps to follow to try to keep them from getting bad, including two staff to be present for all care". The LNA also stated that turning the call light off at the desk instead of in the room helps, because you have to lean over the bed to get to it".</p> <p>Interview of the Social Worker for American Way unit and the Social Worker from unit D, where Resident #1 resided prior to a room change late</p>	F 279		

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F 279	Continued From page 10 in June, on 09/13/12 at 4:00 P.M., revealed that Resident #1 had always displayed verbal behaviors. They stated that after the move, the end of June 2012, Resident #1's behaviors improved and recently started to return to previous patterns. They confirmed staff on the Resident's current unit may not be aware of that behavioral history. During review of the plan of care at that time, both confirmed that there were no specific interventions listed to manage Resident #1's behaviors and stated that is why the Plan of Action in case of escalating behavior was developed on 09/12/12. They stated that staff were being in-serviced on the plan of action but that was ongoing, at shift change each day and all staff had not been in-serviced. They verified that the LNA's suggestion to turn the light off at the desk was not included and was a good suggestion to help prevent escalation for this resident.	F 279	F 282 Resident #1 was struck in the face by a staff member. We took the following actions immediately: 1) Nurse #5 self-reported this incident 2) Nurse #5 was removed from the building immediately and placed on administrative leave 3) local law enforcement authorities were notified 4) Resident #1 was sent to the emergency room for evaluation. A root cause analysis was conducted for Resident #1 and the findings are outline below. Resident #1 was evaluated by an ENT on 9/14/12. The ENT determined that there are no nasal fractures present the resident does have a chronic deformity of the nasal septum as a result of reconstructive surgery after removal of Squamous Cell CA of the face. The resident denies pain at this time and behaviors are currently improved with recent changes to the behavior care plan. Care plan interventions include two care givers at all times, always approach resident from the front in a calm manner, do not lean over the resident to shut off call light, a discussion was	
F 282 SS-J	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 clinical record review and interview, the facility failed to implement the plan of care for management of one resident's behaviors. This affected one (Resident #1) resident in the applicable sample. Findings include: Review of an Event Reporting Form submitted	F 282		

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FORM APPROVED
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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 282	<p>Continued From page 11</p> <p>to the Division of Licensing and Protection by the Director of Nursing on September 13 revealed that LPN # 5 reported to a Nursing Supervisor that LPN # 5 struck Resident # 1 in the face on September 11, 2012. Review of a September 11, 2012 Physician Communication note signed by a facility RN reveals a notation that Resident # 1 was punched in the nose by staff.</p> <p>Review of the record for Resident #1 on 09/13/12, revealed an admission date of 12/19/11 and diagnoses of depression, recent facial herpes zoster, recent suicidal ideation, squamous cell carcinoma of the face with radiation and reconstructive surgery, right molar facial mass, and diabetes. The most recent Minimum Data Set Assessment (MDS) dated 09/04/12, indicates Resident #1 has moderately impaired cognitive function with no short or long term memory problems. The mood severity score is seven and indicates Resident #1 reports daily hopelessness, is short tempered, and had one recent expression of the desire to inflict self harm. The MDS indicates care is rejected 4-6 of 7 days. Resident #1 requires limited assistance (non weight bearing) of one staff for bed mobility, transfer, locomotion off the unit, dressing, personal hygiene and bathing. Resident #1 is independent with eating, toileting, and locomotion on the unit.</p> <p>The plan of care for behavioral symptoms, dated 05/11/12, indicates Resident #1 has behavioral symptoms related to being verbally abusive to staff and other residents, and can be resistive to care being offered. On 08/28/12 an additional notation was made of suicidal ideation related to</p>	F 282	<p>conducted with the resident to change his room configuration so that staff do not have to lean over him and invade his personal space, if agitation is noted leave the resident and re-approach at a later time.</p> <p>As a result of the root cause analysis the following changes to our system will be implemented: facility leadership met with staff on all shifts to inquire as to what happened with Resident #1 and to determine what can be done to prevent this in the future. These suggestions were added to Resident #1's care plan. All residents identified with behaviors that are difficult to alter will have visits by the Social Worker twice a month to discuss the behaviors and interventions that would alter the behaviors. Nursing staff will document all behaviors on the behavior monitoring forms. The care plans will be revised as warranted from these visits and referrals made to psychological services as necessary.</p> <p>Nursing staff have had education started on September 11, 2012 regarding revising and following the plan of care</p>	

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F 282	<p>Continued From page 12</p> <p>pain and on 09/12/12 a notation of physical abuse towards others. An undated notation indicates Resident #1 has ongoing behaviors such as throwing items at staff and foul language as evidenced by nurses notes on 04/10/12 and previous. The goal stated for Resident #1 indicates the resident should have improved or maintain acceptable behavior through next review. The interventions include 1) Assess, monitor and document unacceptable behaviors. Observe what may trigger these behaviors, document and notify the MD. 2) Intervene to ensure the safety of the Resident and others, encourage to ask for assistance and ring the call light 3) Visual checks only at night - do not wake up - per Resident request. 4) Anticipate the needs of the resident before the resident becomes overly stressed. Approach calmly. 5) Provide 1:1 time for resident to express feelings and concerns. 6) Maximize strengths and positive behaviors. Offer meals in room with increased behaviors. 7) Administer medications as ordered. Observe for effectiveness and side effects.</p> <p>Review of the behavior/intervention monthly flow record for 08/2012 revealed that agitation/irritability as evidenced by verbal abuse was documented on day shift on 08/10/12 and positive results were noted from redirection and reapproach. On 08/29/12 no results were noted from redirection, 1:1, return to room, or position change when attempted. The record for 09/2012 revealed that agitation, as evidenced by verbal abuse, was displayed on 09/01/12, 09/02/12 and 09/03/12. Intervention included redirect, 1:1 and re approach and were effective only on 09/03/12. No behaviors were documented on 09/11/12</p>	F 282	<p>this education will be ongoing.</p> <p>The Director of Social Services will conduct an audit every two weeks on residents with noted behaviors to ensure weekly visits by the Social Worker are occurring. The Director of Nursing Services or designee will conduct audits to ensure that the physician is notified of issues as warranted and the plan of care is revised to reflect their current status.</p> <p>Data from the audits will be brought to the Quality Assurance meeting bi-monthly for six months or until the committee has determined resolution. The Director of Nurses is ultimately responsible to ensure that care plans are developed and reflect the resident's status.</p> <p>Completion Date: September 25, 2012</p>	

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F 282	<p>Continued From page 13</p> <p>Review of the nurses notes for 09/2012 revealed no documented behaviors for 09/2012 and the documentation on 09/11/12 specifically, did not indicate behaviors. A care plan meeting note was made on 09/11/12 and was untimed. It indicated Resident #1 did not attend and the same plan of care was to continue. No documentation was located to indicate that staff attempted to remove Resident #1 from the dining room on the evening of 09/11/12.</p> <p>Review of Situation, Background, Assessment, Request (SBAR) form dated 09/11/12 revealed that on 09/11/12 at 7:10 P.M., Resident #1 was "punched in the nose by staff" LPN #5. The attached progress note indicated that the Registered Nurse supervisor was called to the American Way unit at 7:10 P.M. on 09/11/12, when Resident #1 reported being hit in the nose by staff. Staff reported Resident #1 had been agitated, calling them names and throwing things throughout the evening.</p> <p>Interview of the LNA who cared for Resident #1 on 09/11/12 revealed that on that date many different people were in and out of Resident #1's room. The LNA indicated that Resident #1 had daily verbal outbursts and they were worse on this date. The LNA confirmed that Resident #1 was displaying severe verbal outbursts and cursing in the dining room on 09/11/12 at the evening meal. The LNA indicated that the Resident was not removed from the dining room during the outbursts.</p> <p>Interview of the Social Worker for American Way unit and the Social Worker from Unit D, where Resident #1 resided prior to a room change late</p>	F 282			

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F 282	Continued From page 14 in June, on 09/13/12 at 4:00 P.M., revealed that Resident #1 had always displayed verbal behaviors. Both reviewed the behavior/intervention flow records for 08/2012 and 09/2012 and verified that daily behaviors were reported by staff but not documented per the plan of care and reported they were unaware of increased behaviors until the 09/11/12 incident. Interview of the DNS and Administrator on 09/13/12 at 4:15 P.M. confirmed that staff reported daily behaviors but did not document the behaviors per the plan of care. The DNS stated "we have identified that and are in the process addressing it".	F 282	F 514 Resident #1 was struck in the face by a staff member. We took the following actions immediately: 1) Nurse #5 self-reported this incident 2) Nurse #6 was removed from the building immediately and placed on administrative leave 3) local law enforcement authorities were notified 4) Resident #1 was sent to the emergency room for evaluation. A root cause analysis was conducted for Resident #1 and the findings are outline below.	
F 514 SS-D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, the facility failed to ensure accurate	F 514	Resident #1 was evaluated by an ENT on 9/14/12. The ENT determined that there are no nasal fractures present the resident does have a chronic deformity of the nasal septum as a result of reconstructive surgery after removal of Squamous Cell CA of the face. The resident denies pain at this time and behaviors are currently improved with recent changes to the behavior care plan. Care plan interventions include two care givers at all times, always approach resident from the front in a calm manner, do not lean over the resident to shut off call light, a discussion was	

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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 514	<p>Continued From page 15</p> <p>documentation of the behaviors exhibited by Resident #1. This affected one (Resident #1) resident in the applicable sample. Findings include:</p> <p>Review of the record for Resident #1 on 09/13/12, revealed an admission date of 12/19/11 and diagnoses of depression, and recent suicidal ideation. The most recent Minimum Data Set Assessment (MDS) dated 09/04/12, indicates Resident #1 has moderately impaired cognitive function with no short or long term memory problems. The mood severity score is seven and indicates Resident #1 reports daily hopelessness, is short tempered, and had recently expressed a desire to inflict self harm. The MDS indicates care is rejected 4-6 of 7 days.</p> <p>The plan of care for behavioral symptoms, dated 05/11/12, indicates Resident #1 has behavioral symptoms related to being verbally abusive to staff and other residents, and can be resistive to care being offered. On 08/28/12 an additional notation was made of suicidal ideation related to pain and on 09/12/12 a notation of physical abuse towards others. An undated notation indicates Resident #1 has ongoing behaviors such as throwing items at staff and foul language as evidenced by nurses notes on 04/10/12 and previous. A physician's order dated 08/23/12 discontinued multiple medications, including an antidepressant. The corresponding progress note indicated the Resident had been refusing medication for greater than one week and had requested all medication be stopped. The medication administration record indicated Resident #1 did not receive medication on one</p>	F 514	<p>conducted with the resident to change his room configuration so that staff do not have to lean over him and invade his personal space, if agitation is noted leave the resident and re-approach at a later time.</p> <p>As a result of the root cause analysis the following changes to our systems will be implemented: facility leadership met with staff on all shifts to inquire as to what happened with Resident #1 and to determine what can be done to prevent this from happening in the future. All residents identified with behaviors that are difficult to alter will have visits by the Social Worker twice a month to discuss the behaviors and interventions that would alter the behaviors. Nursing staff will document all behaviors on the behavior monitoring forms. The care plans will be revised as warranted from these visits and referrals made to psychological services as necessary.</p> <p>Nursing staff will begin to be educated on documenting behaviors on the behavior forms and in the nurses' notes as warranted on September 28, 2012</p>	

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F 514	<p>Continued From page 16</p> <p>day, 08/23/12. The reason was not documented.</p> <p>Review of the behavior/intervention monthly flow record for 08/2012 revealed that agitation/irritability as evidenced by verbal abuse was documented on day shift on 08/10/12 on 08/29/12. The record for 09/2012 revealed that agitation, as evidenced by verbal abuse, was displayed on 09/01/12, 09/02/12 and 09/03/12. No behaviors were documented on 09/11/12 when the Resident allegedly struck a staff member. Review of the nurses notes for 09/2011 revealed no documented behaviors for 09/2012 and the documentation on 09/11/12 specifically, did not indicate behaviors. A care plan note was made on 09/11/12 and was untimed. It indicated Resident #1 did not attend and the same plan of care was to continue.</p> <p>Interview of the RN caring for Resident #1 on 09/13/12 at 11:50 A.M. revealed that Resident #1 "has never been very nice, but has had increased behaviors lately". When asked to elaborate the RN stated "since the antidepressant was discontinued. I think for refusal, but [Resident #1] always takes medications for me". The RN indicated that Resident #1 typically displayed verbally abusive behaviors. Interview of the LNA who cared for Resident #1 on 09/11/12 and on 09/13/12 on evening shift was conducted on 09/13/12 at 3:30 P.M. and revealed that Resident #1 had daily verbal outbursts.</p> <p>Interview of the Social Worker for American Way unit and the Social Worker from unit D, where Resident #1 resided prior to a room change late in June, on 09/13/12 at 4:00 P.M., revealed that</p>	F 514	<p>The Director of Social Services will conduct an audit every two weeks on residents with noted behaviors to ensure weekly visits by the Social Worker are occurring. The Director of Nursing Services or designee will conduct audits to ensure that the physician is notified of issues as warranted and the plan of care is revised to reflect their current status.</p> <p>Data from the audit will be brought to the Quality Assurance meeting bi-monthly for six months or until the committee has determined resolution.</p> <p>The Director of Nursing is ultimately responsible to ensure that care plans are developed and reflect the resident's status.</p> <p>Completion Date: September 25, 2012</p>	