VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

March 7, 2025

Ms. Melissa Jackson, Administrator
Vermont Veterans' Home
325 North Street
Bennington, VT 05201-5014

Dear Ms. Jackson:

Enclosed is a copy of your acceptable plans of correction for the recertification survey that was conducted in conjunction with a complaint investigation on **January 29, 2025.** 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, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475032	A. BUILDING _____ B. WING _____	C 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERMONT VETERANS' HOME	325 NORTH STREET BENNINGTON, VT 05201

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E 000	Initial Comments The Division of Licensing and Protection conducted an onsite, unannounced survey of the facility's emergency preparedness program on 1/29/2025 during an annual recertification survey. There were no regulatory violations as a result of this survey.	E 000	Filing of this Plan of Correction does not constitute any admission as to the alleged violation set forth in the State of Deficiency. This Plan of Correction is being filed as evidence of the facility's continued compliance with all applicable laws and regulations.	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and investigation of eight facility reported incidents, including reports #23674, #22710, #22711, #22782, #22832, #23118, #23088, #23089 from 1/27/2025 through 1/29/2025 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F 000		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 4 out of 17 sampled residents (Resident #13, #17, #40, #52) received sufficient supervision to prevent resident to resident altercations, and failed to ensure the environment remains as free of accident hazards as is possible for 1 of 17 sampled residents	F 689	Resident[s] affected: 1. Resident #40 had Their care plan reviewed and revised to keep the Veteran independent, safe and to prevent injuries to others. If resident #40 is on the porch with resident # 52 a staff member will be present or resident #40 will be redirected to another area. 2. Resident #52 had their care plan reviewed and revised to keep the Veteran independent, safe and to prevent harm from other Veterans. If resident #52 is on the porch with resident # 40 a staff member will be present or resident #40 will be redirected to another area.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Docusigned by: Melissa Jackson 7FAAD5868D145E...	CEO	02/20/25

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 (Resident # 1). Findings include: 1). A facility investigation report of a resident to resident altercation on 6/20/24 submitted to the State Agency stated "staff heard veterans yelling in the porch area. When staff found the two residents [Resident #40] was holding [Resident #52's] right forearm. [Resident #52] stated, [S/he] hit me." Per the facility investigation, both residents were in the porch area without staff present when the altercation occurred. Per an Incident Note dated 6/13/24, "[Resident #52] had red areas on the right lateral forehead and one red area on the left temple and mild redness on right lateral forearm". Per review of Resident #40's care plan dated 8/24/22 "[Resident #40] mood can be labile going from happy go lucky to angry. During [his/her] angry outbursts [S/he] can have verbal aggression; yelling, screaming, and using abusive language with a history of resident to resident altercations. [S/He] can become physically aggressive and violent [toward staff and other residents]." Interventions per his/her care plan include "anticipate and meet resident needs." Per review of Resident #52's care plan dated 2/14/23 "[Resident #52] has a diagnosis of Alzheimer's disease and anxiety. Sometimes [his/her] reality can be disturbing, and [S/he] will be upset, anxious and use vulgar language ... During these alternate realities [Resident #52] can become quite argumentative and agitated. During these times [S/he] may raise [his/her] fist, kick, hit or push [others], resident has history of resident altercations and per his/her care plan [Resident #52] is at risk to wander r/t dementia, disoriented to place, Impaired safety awareness."	F 689	3. Resident #17 had Their care plan reviewed and revised to keep the Veteran independent, safe and to prevent injuries to other Veterans. Resident #13 will be offered a “Stop” strip door Banner to help prevent other veterans from entering resident #17 room 4. Resident #13 had Their care plan reviewed and revised to keep the Veteran independent, safe and to prevent further injuries to the resident when wandering. When resident #13 is observed wandering hallway staff will encourage activities and redirect away from other veterans’ rooms 5. Resident #1 Toilet paper holder was removed and placed in an area higher to prevent further injuries Resident[s] who have the potential to be affected: 1. A house audit was completed on residents’ behaviors who have the potential to harm others or to be harmed. 2. Resident behavior care plans were reviewed and if needed revised to ensure interventions are in place to help prevent harm to other residents	

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F 689	Continued From page 2 Per further review of his/her careplan, on 4/19/2023 "[Resident #52] wandered into another Veteran's room which resulted in an altercation." The care plan includes the following intervention dated 10/30/23," When [Resident #52] becomes irritable and agitated and stands up, go with it! Use this as an opportunity to walk [him/her] away from the person or situation." Per the Facility Assessment dated 2/14/24, the facility cares for residents with "mental and behavioral health diagnosis that include complex mental health, medical conditions and medication- related issues causing psychiatric symptoms and behavior[s]." The facility's goal per report is to identify and implement interventions to help support individuals with these through the assessment of the [individual residents], early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions ..." There was no evidence provided by the facility that staff were providing supervision to Resident #40 or Resident #52 while on the porch on 6/14/24. Per interview on 1/29/25 at 2:00 PM with the Deputy Administrator and the Chief Executive Officer, both confirmed that Resident #40 and Resident #52 were on the porch together without supervision with a history of resident-to-resident altercations. 2). Per record review, Resident #17 has a care plan focus dated 5/11/23 that states "[S/he] has repeatedly gone into other Veterans' rooms. [S/he] can be difficult to redirect from theses space[s]." Resident #17's care plan does not have any interventions in place to provide supervision or to address Resident #17's	F 689	3. Staff were re-educated on the importance of re-directing residents away from potential harm. Staff were also re-educated on providing “Supervision” in common areas when there is a need to prevent injuries 4. A house audit was completed on all resident bathrooms ensuring that their toilet paper holder is at an appropriate height if not it was removed and placed in another area in the bathroom 5. Staff were re-educated on the need to report any resident concerns to their Supervisor and/or Manager -timely. Systemic Changes: 1. The IDT team will discuss veteran[s]/resident[s] behaviors during morning clinical mee-ng to ensure behavior interventions have been reviewed and updated timely and if needed the behavior care plan will be revised at morning clinical 2. The resident/veteran[s] Behavior care plan will be attached to any Behavior incident report to be reviewed for new interventions 3. All new Behavior Interventions will be added to the Unit communication book so staff can review any behavior changes and/or interventions when arriving on duty	

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F 689	Continued From page 3 wandering or entering other residents' rooms. Per a progress note dated 6/13/2024, Resident #17 was self propelling down a hallway. Resident #13 was walking in the opposite direction, and when Resident #17 passed, Resident #13 turned and tapped him/her on the head. Resident #17 stopped propelling and raised his/her arm. An Incident Note dated 6/14/24 stated Resident #13 was at the end of the hall and was seen by a staff member "standing behind the wheelchair of [Resident #17], pulling [his/ her] hair and hitting [him/her] on the top of the head. [Resident #13] stated that s/he is sick of [Resident#17] opening [his/her] door." Per facility investigation on 6/14/24 "[Resident #13] was trying to stop [Resident #17] from going into his room." Per the facility investigation, the event occurred near the end of the hall outside of Resident #13 room. During an interview on 1/29/25 at 2:00 PM with the Deputy Administrator and the Chief Executive Officer, both confirmed that the above incidents occurred at the facility. 3) Per observation and interview on 1/27/25 at 10:45 AM, Resident #1 had multiple scratches and abrasions in various states of healing on each of his/her knees. Resident #1 stated that when s/he transfers from their wheelchair using the grab bar mounted to their bathroom wall with a 1-person physical assist, they often scrape their knees on the toilet paper holder that is mounted to the wall next to the toilet. Resident #1 stated that they have asked several LNAs [licensed nursing assistants] to "please get someone to move this toilet paper holder" as it is hurting their knees on a regular basis. Resident #1 expressed feeling upset and disrespected stating that "All I	F 689	Quality Assurance Monitoring: 1. The Director of Behavioral Health and/or designee will randomly audit 10% of the behaviors each month x90-days to ensure the timeliness of interventions 2. The Director of Behavioral Health and/or her designee will report their findings of the audit at the month QAPI 3. The Administrator has overall responsibility for this Tag Completion Date March 15, 2025 **Tag F 689 POC accepted on 3/6/25 by J. Schneckenburger/S. Stem**	

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F 689	Continued From page 4 ever did was go fight in a war for them, I guess it is too much to ask [to have the toilet paper holder moved]." Facility policy "VVH [Vermont Veterans Home] Policy & Procedure Maintenance Repair Requisitions" (effective date 5/11/22) states, "It is the policy of this facility that maintenance repair requisitions will be generated by staff to provide notice and a record of repairs as necessary...Repair requests are to be entered into the MaintenanceCare system which can be accessed via VVH computer. Veterans/Members, Visitors, etc. are to notify staff members of their maintenance requests and staff will enter their requests into the MaintenanceCare system." In an interview on 1/28/25 at 4:10 PM, the Unit Manager confirmed that all staff have access to an online portal to enter maintenance requests and all staff are expected to do so if a resident asks them to. In an interview on 1/29/25 at 12:40 PM with the Director of Environmental Services, they confirmed that over the last 12 months no staff member has entered Resident #1's request to have their toilet paper holder moved. The Director of Environmental Services confirmed that all staff on the unit have access to the online portal for maintenence requests and should have entered this request into the system per facility policy.	F 689		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with	F 699		

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F 699	Continued From page 5 professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that two residents [Res. #29 & #33] of 13 sampled residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Findings include: 1. Per review of Res.#29's medical record, the resident was admitted to the facility with diagnoses that include Post Traumatic Stress Disorder [PTSD]. Review of Physician Notes dated 12/27/24 record the resident "is well known to myself and the staff here from past admissions." The Physician recorded "when [Res.#29] gets irritable, [s/he] goes and hides because afraid [s/he] will "blow up," "at high risk of decompensation," "very depressed, Military History: Army/ combat / communications - was all over Vietnam / still with flashbacks at times," "startles easily - if have to awaken [h/her] - touch toes and call [h/her]." An interview was conducted with Social Services [SS] on 1/28/25 at 4:12 PM. SS stated that the facility utilizes a 'Behavioral Health Clinical Assessment' as an assessment tool to identify concerns related to the resident's condition and plan of care.	F 699	Resident[s] affected: 1. Resident #29 had a new Trauma assessment completed and his care plan for PTSD was reviewed and if needed revised 2. Resident # 61 had a new Trauma assessment completed and his care plan for PTSD was reviewed and if needed revised Resident[s] who have the potential to be affected: 1. A House audit was completed on resident[s] who have a diagnosis of PTSD ensuring that they have been assessed for Trauma 2. Once the audit was completed their care plans were reviewed and if needed revised to reflect interven-ons specifically to their PTSD 3. Behavioral Health staff were re-educated on the importance of assessing residents for Trauma and ensuring a plan of care has been developed at the time of admission Systemic Changes: 1. The admission nurse will notify Behavioral Health of any residents with PTSD 2. The MDS nurses will review the Trauma assessment for completion prior to the initial care plan meeting	

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F 699	Continued From page 6 Review of Res.#29's Behavioral Health Clinical Assessment dated 1/27/25 records the "Admission Reason/Presenting Problem" as "respite and recovery." Further review of the Behavioral Health Clinical Assessment for Res.#29 reveals no further information recorded. Blank areas in the assessment include: -Summary of Current Mental Health or Psychiatric Issues -History of trauma -Type of trauma experienced -Symptoms experienced -Triggers -Identified needs -Recommended services/plan of care Review of Res. #29's Care Plan revealed the resident as not identified as suffering from PTSD, and no interventions identified related to experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Per interview with Social Services [SS] on 1/28/25 at 4:12 PM, SS confirmed that Res. #29 was well known to the facility as diagnosed with PTSD. SS confirmed the resident was not care planned for h/her diagnosis of PTSD and was not assessed for trauma-related care and should have been. 2. Per record review, Resident #61 was admitted to the facility with a diagnosis of PTSD, anxiety, and depression. A document that is titled "Behavioral Health Clinical Assessment," dated 9/14/24 identifies that Resident # 61 has a history of trauma. The section "Type of trauma experienced" is not completed. The form does not contain any further information. Per review of Resident #61's record, no evidence	F 699	Quality Assurance Monitoring: 1. The Director of Behavioral Health and/or designee will randomly audit 10% of the Trauma admissions each month x90 days to ensure timeliness of assessment and care plan 2. The Director of Behavioral Health and/or her designee will report their findings of the audit at the month QAPI 3. The Administrator has overall responsibility for this Tag Completion Date March 15, 2025 **Tag F 699 POC accepted on 3/6/25 by J. Schneckenburger/S. Stem**	

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F 699	Continued From page 7 was found that the resident was assessed for triggers that may re-traumatize the resident. No evidence was found in Resident 61's plan of care regarding the resident's triggers or how staff can provide care that avoids re-traumatizing the resident. Per an interview on 1/28/2025 at approximately 4:15 PM with Social Services and the Director of Social Services, the Licensed Social Worker indicated s/he was not aware of a trauma assessment format that the facility uses, and had not been assessing the residents for triggers related to their traumas as outlined in the facility policy. The Director of Social Services confirmed that Resident #61's trauma-specific triggers had not been identified , and Resident #61 should have had a trauma care plan.	F 699		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(f) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services;	F 790	Resident affected: 1. Resident # 26 was seen be the Dentist on 2/3/25. A plan was discussed with the resident and the Dentist notified VA for approval Resident[s] who have the potential to be affected: 1. A Dental House audit was completed on all residents 2. Once the audit was completed it was reviewed to ensure that residents have had follow up timely if not their physician/dentist has been notified 3. Nursing staff will be re-educated on the facility Dental process and the importance of documenting their appointment	

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F 790	Continued From page 8 §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide routine dental services for 1 resident [Res. #26] of 3 residents sampled with identified dental issues. Findings include: Per review of Res. #26's medical record, the resident was admitted to the facility with diagnoses including dysphagia [a condition with difficulty in swallowing food or liquid]. Review of Res. #26's Nutrition Assessment conducted for admission to the facility dated 10/28/2024 assessed the resident as having "some 'chewing' difficulty related to temporary dentures only" with the resident "edentulous" [lacking teeth], "Has temporary dentures. Needs permanent ones."	F 790	Systemic Changes: 1. The Medical Records staff will track Dental visits and place all referrals in a binder which will be kept in their office 2. The Medical records staff will notify all CCC {unit managers} of the residents that are being assessed by the Dentist on the day of their visit 3. The Dentist visit[s] will be discussed with the team at the end of day meting Quality Assurance Monitoring: 1. The Director of Nurses and/or designee will randomly audit 10% of the Dentist visit each month x90-days to ensure timelines of follow up 2. The Director of Nurses and/or her designee will report their findings of the audit at the month QAPI 3. The Administrator has overall responsibility of this Tag Completion Date March 15, 2025 **Tag F 790 POC accepted on 3/6/25 by J. Schneckenburger/S. Stem**	

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F 790	Continued From page 9	F 790		

Further record review reveals Res. #26 was seen by a dentist on 10/31/24. Dental Notes record "The patient had teeth extracted in June or July" and "expected a new set [of dentures] to be made after healing. I will contact [Veterans Administration] and see what has been approved and whether I can take over here."

An interview was conducted with Res. #26 on 1/27/25 at 3:00 PM. Res. #26 stated "There is one thing I would like; to know when my next dentist appointment is. I was seen and told I need new dentures and I have not heard anything since."

Review of Res. #26's Nutrition Assessment dated 1/27/25 records the resident "at nutritional risk" with the resident "reports some trouble chewing related to being edentulous with only temporary dentures. Saw dentist on 10/31/24. Needs permanent dentures per MD." Review of Res. #26's Care Plan confirms the resident is "edentulous with only temporary dentures...Needs permanent dentures per MD."

An interview was conducted with Res. #26's Unit Manager [UM] on 1/28/25 at 4:25 PM. The UM confirmed that Res.#26 was identified as needing dentures upon admission in October 2024. The UM stated that after the resident saw the dentist on 10/31/24 the facility's process is to reach out to the Veterans Administration per the dentist's instructions to see if services were in place. The UM confirmed this was not done and could not ensure that the resident's need for new dentures was being addressed.