VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

[phone] 802-241-0344
[fax] 802-241-0343

AGENCY OF HUMAN SERVICES

April 7, 2026

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

Provider ID #: 475032

Dear Ms. Jackson:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **March 11, 2026.** 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
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Veterans' Home	325 North Street , Bennington, Vermont, 05201

(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
E0000	Initial Comments The Division of Licensing and Protection conducted an unannounced, onsite emergency preparedness review on 3/11/26 during the annual recertification survey. There were no regulatory violations identified.	E0000	The filing of this plan of correction does nt constitue an admission of guilt. The Vermont Veterans' Home ("the provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements.	
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and investigation of one facility reported incident, including report(s) #2746733, from 3/9/26 through 3/11/26 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F0000	F0584 New toilet backrests were ordered on 3/25/26 and they will be installed upon delievery. Room number signs for rooms 509 and 611 were installed on March 12, 2026. The chiped paint on the bathtub and bath seat were repaird on April1, 2026. The ceiling on this neigbhor is scheduled for replacement and the replace-ment will be completed by Apri 25, 2026. Evniromental rounds were completed on all neighborhoods to identify resident rooms without room numbers, damaged ceiling tiles, bathing suites needing repairs. Any repairs needs were entered into the facility's maintenance repair system and classified as a high priority repair. These items will be repaired within seven days unless parts are on order to complete the repair. The Director of Enviormental Services or designee will conduct 2 random enviormental audits of the nursing neigbhorhoods or other areas of the facility to monitor for compliance with environmental standands. The goal is to achieve and maintain 95% compliance with the enviormental standards. Audits will take place weekly x 4 weeks, twice monthly x 1 month and monthly x 1 month. Results from these audits will be reviewed at the Monthly QAPI meeting . Audits will continue until the committe determines sustained	
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and	F0584		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa A. Jackson	CEO	04/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Veterans' Home	**325 North Street , Bennington, Vermont, 05201**

(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
F0584 SS = E	Continued from page 1 comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure a safe, clean, comfortable and homelike environment for residents who reside on one of three units of the facility. Findings include: Per observation on 3/9/26 at 1:53 PM in the bathing room on the 500 halls of the Cardinal memory care unit, the tub had chipped paint on both the seat and the tub itself. There were damaged tiles and debris in one of the two shower stalls. The toilet backrest had cracks in the padding and rust on the framing. On both the 500 and 600 halls of the Cardinal memory care unit, there were stained and damaged ceiling tiles, including outside of Room 601. The room number signs were missing outside of Rooms 509 and 611, with the room numbers instead written in with magic marker on the walls outside the room. These items were reviewed and confirmed per interview and tour with the Administrator, Director of Nursing, and Quality Assurance Nurse on 3/11/26 at 10:45 AM.	F0584	compliance has been achieved. The Director of Enviromental Service is reponsible for compliance. Compliance Date: April 25, 2026, **Tag F0584 POC accepted on 4/2/26 by W. White/S. Stem**	
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans	F0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Veterans' Home	**325 North Street , Bennington, Vermont, 05201**

(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
F0655 SS = D	Continued from page 2 §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.	F0655	F0655 Baseline Care PLan Resident # 3 has expired. The facility audited all new admissions for the past 90 days to ensure basline care plans were complete. Staff education on baseline care plans began on April 1, 2026 and will continue until completed The Chief Nursing Officer or desingee will audit all new admission x 90 days to ensure base line care plans are completed within 48 hours.With a goal of maintaining 100% compliance with completion of baseline careplans in 48 hours. The results of the audits will be reviewed at the facility's monthly QAPI meeting. Audits will continue until the committee determines sustained compliance has been achieved. The Chief Nursing Officer is responsible for compliance. Compliance Date: April 25, 2026 **Tag F0655 POC accepted on 4/2/26 by W. White/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Veterans' Home	**325 North Street , Bennington, Vermont, 05201**

(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
F0655 SS = D	Continued from page 3 This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to develop a baseline care plan that addressed the smoking needs of 1 of 2 residents in the applicable sample (Resident #93). Findings include: Per a record review, Resident #93 was admitted to the facility on 2/11/26 with diagnoses that included nicotine dependence and respiratory failure. A smoking assessment dated 2/11/26 states that Resident #93 is capable of holding his/her own cigarette and smoking unsupervised. The assessment also states that his/her lighter would need to be secured by nursing and would be available as needed. A nursing progress note dated 2/12/26 states that Resident #93 went to smoke several times that day and “had to be reminded repeatedly to wear O2 (oxygen).” Another nursing progress note dated 2/13/26 states that the Resident went to smoke that day. Further review of nursing progress notes reveals that on 2/16/26 at 6:51 am Resident #93 approached the door of the North unit medication room with black soot on their nose and their oxygen tubing was burnt. The Resident stated that their cigarette had caught on fire from their oxygen. The progress note also states that the Resident had left the unit and went to the smoking room with their oxygen in place. Another Resident in the smoke room lit the cigarette. The other Resident stated that Resident #93 took 2 puffs of the cigarette and then it caught fire in his/her face. The fire went out by itself and Resident #93 left the smoking room. Resident #93 sustained a superficial burn to his/her face with a width of 0.67 centimeters, length of 1.53 centimeters and area of 0.58 centimeters, noted to be painful. A nursing progress note dated 2/16/26 at 7:55 pm states the skin was burned off the tip of Resident #93’s nose after his/her smoking-room incident. Review of Resident #93’s care plan that was in place while he/she was a resident of the residential care unit initiated 6/2/25 revealed that it did not address his/her smoking status, including the resident’s use of oxygen, until 2/17/26, the day after the resident sustained a facial burn when his/her cigarette was lit while s/he was using oxygen. During an interview with the ADON (Assistant Director	F0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Veterans' Home	**325 North Street , Bennington, Vermont, 05201**

(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
F0655 SS = D	Continued from page 4 of Nursing) on 3/11/26 at 11:06 AM, the ADON confirmed that the care plan from the residential care unit would be considered the baseline care plan on admission to the long-term care facility. The ADON was unable to provide documented evidence that the Resident's baseline care plan addressed the smoking needs that were reflected in the Resident's smoking assessment until 2/17/26, the day after the incident. The facility policy titled "Smoking Policy Nursing Home – Veteran & Members," states "any smoking related privileges, restrictions, and concerns (for example, need for close monitoring) are noted in the care plan, and all personnel caring for the Veteran & Member shall be alerted to these issues. (Revision 8/15/22)"	F0655		
F0689 SS = G	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 interview and record review, the facility failed to ensure a resident remained as free from accidents as possible related to the use of supplemental oxygen while smoking and failed to maintain effective supervision that would reduce the likelihood of incident or injury for 1 of 2 residents in the applicable sample (Resident #93). As a result, Resident #93 suffered a facial burn that resulted in pain, redness, and loss of skin. This is a repeat deficiency for this facility, with the violation cited during the previous re-certification survey, dated 1/29/25. Findings include: Based on interview and record review, the facility failed to ensure a resident remained as free from accidents as possible related to the use of supplemental oxygen while smoking and failed to maintain adequate supervision for 1 of 2 residents in the applicable sample (Resident #93). As a result, Resident #93 suffered a facial burn that resulted in	F0689	"Past Noncompliance - no plan of correction required"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Veterans' Home	**325 North Street , Bennington, Vermont, 05201**

(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
F0689 SS = G	Continued from page 5 pain, redness, and loss of skin. Findings include: Per a record review, Resident #93 was recently admitted to the facility's long term care unit from residential care due to increased care needs, with diagnoses that included nicotine dependence and respiratory failure. A smoking assessment completed on 2/11/26, noted Resident #93 as an unsupervised smoker who is allowed to keep their cigarettes with them but needs to request their lighter when they wish to smoke. Nursing progress notes dated 2/16/26, reflect that the resident had increasing agitation and confusion throughout the night requiring increased staff supervision and was receiving 4 liters of continuous oxygen via nasal canula. A nursing progress note written at 6:51 am states that at 6:20 am nursing staff observed black soot on the Resident's nose and burned oxygen tubing under their nose. When nursing staff asked the Resident what had happened s/he stated that another resident had lit his/her cigarette, and it had caught on fire. The note also states that Resident #93 sustained a burn to his/her face with a width of 0.67 centimeters, length of 1.53 centimeters and area of 0.58 centimeters, noted to be painful. Review of Resident #93's care plan revealed that the facility had failed to care plan his/her smoking status, including the hazard of Resident 93's oxygen, until 2/17/26, the day after the resident sustained a facial burn when his/her cigarette was lit while s/he was using oxygen. The facility policy titled Smoking Policy Nursing Home – Veterans & Members, revised 8/15/22, states that oxygen use is prohibited in smoking areas. Per interview with the DON (Director of Nursing) on 3/11/26 at 3:31 PM, she confirmed that Resident #93 went to the smoking room with his/her oxygen on and sustained a burn due to his/her cigarette being lit. She also confirmed that a sign prohibiting the use of oxygen in the smoking room was not placed on the smoking-room door until after Resident 93's burn injury was sustained. Ref. F655 Based on corrective actions completed prior to the onsite, this citation is designated as past non-compliance. The following actions were completed by the facility:	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Veterans' Home	**325 North Street , Bennington, Vermont, 05201**

(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
F0689 SS = G	Continued from page 6 Resident #93 continued to have supervision with smoking and was reassessed per facility policy. The facility reassessed all residents who smoke to ensure assessments and care plans are up to date. The facility updated their smoking policy to clearly define the steps to be taken when the resident who is on oxygen is also a smoker. All independent smokers were re-educated that they are not to assist other smokers with lighting their cigarettes, as well as how to call for assistance from the smoking room and the location of the nearest fire alarm pull station. Staff were educated on the updates to the resident smoking policy. A security camera was installed in the smoking room to provide a recording that can be reviewed if future incidents take place. Signage was posted in the smoking-room regarding emergency procedures and the prohibition of oxygen in the smoking room. The administrator is auditing changes in conditions in smoking residents that might impact their smoking.	F0689		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F0761	F0761 Label/Store Drugs and Biologicals Medication and treatment carts are locked when not in use or when un attended. on 3/11/26 the faciity's medication and treat-ment carts were inspected by our pharmacy vendor to ensure the locking mechanisms were functioning properly. On April 1, 2026 education on medication storage began for the facility's RN and LPN staff and will continue until completed. The RN Supervisor or designee will conduct random audits on each shift to ensure all medication and treatment carts are locked. The goal is 100% compliance. The audits will take place weekly x 4 weeks, twice monthly x 2 months and montly x 1 month. Audit data will be reviewed at the monthly QAPI meeting. Audits will continue until the committee determines sustained compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Veterans' Home	325 North Street , Bennington, Vermont, 05201

(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
F0761 SS = E	Continued from page 7 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interviews the facility failed to ensure all drugs and biologicals were stored in locked compartments for 3 of 7 medication carts on two units. Findings include: Per observation on the Brandon Unit on 3/9/26 at 2:01 PM a medication cart and a treatment cart were found unlocked, with no staff in the hallway. One resident observed ambulating near the medication cart. Per interview with the Registered Nurse (RN) assigned to the medication cart on 3/9/26 at 2:19 PM confirmed the medication and treatment cart were both unlocked. The medication cart contained medications, inhalers, topical patches, syringes, topical medications, Insulins, prescribed resident specific medications and narcotics in a separate locked compartment. The treatment cart contained wound cleansers, prescription topical creams/pastes, and prescription topical powders. Per interview with RN Unit Manager of the Brandon Unit on 3/9/26 at 2:24 PM confirmed that medication carts left unattended in common areas with residents should be locked so that the contents within the cart are not accessible without the key. Per observation on the Brandon Unit on 3/10/26 at 7:54 AM the medication cart was found unlocked. Per interview with RN Unit Manager of the Brandon Unit on 3/10/26 at approximately 8:00 AM confirmed the medication cart was unlocked and it should not be. During observations on the North Village Unit on 3/12/26 at 7:45 AM, the medication cart was found unlocked, with no staff in the corridor and a resident sitting next to it. Per interview on 3/12/26 at 7:48 AM, the Licensed Practical Nurse assigned to the medication cart confirmed that the cart was not locked, as it should be, and that a resident was sitting next to the unlocked, unattended cart.	F0761	has been achieved. The Chief Nursing Officer is responsible for compliance. Complliance Date: April 25, 2026 **Tag F0761 POC accepted on 4/2/26 by W. White/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Veterans' Home	**325 North Street , Bennington, Vermont, 05201**

(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
F0761 SS = E	Continued from page 8 Per review of the facility's policy titled, "Medication Labeling and Storage" it states, "Compartments (including drawers cabinets rooms, refrigerators, carts and boxes) containing medications and biologicals are locked when not in use, and treys or carts used to transport such items are not left unattended if open or otherwise potentially available to others."	F0761		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to store food in accordance with professional standards for food service safety and failed to ensure freezers were maintained at the appropriate temperature. Findings include: Per observation of the kitchen freezer on 3/9/26 at 11:36 AM there was a pack of three sausages and a package of smart dogs opened in the freezer with no date or label. In the dry storage area, there was a 10-pack of instant grits with an expiration date of 11/25. There was a	F0812	F0812 Food Procurement, Store/Prepare/Serve-Sanitary All expried food has been revmoved from the ktichen and the freezers have been inspected to ensure they are functioning properly. Dietary staff education onlabeling, dating, disponsing of expired food, food temperatures and completing a maintenance request began on March 30, 2025 and will continue until completed. The Food Service Supervisor or designee will conduct random audits of the facility's food storage to ensure all expired food has been disposed off as well as random audits of temperature logs to ensure refrigerators and freezers are within allowable temperatures. The goal is 95% compliance. Audits will take place weekly x 4 weeks, twice monthly x 1 month and monthly x 1 month. Audit data will be reviewed at the facility's monthly QAPI meeting. Audits will continue until the committee determines sustained compliance has been achieved. The Food Service Supevisor is resposnbile for compliance Compliance date: April 25, 2026. **Tag F0812 POC accepted on 4/2/26 by W. White/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Veterans' Home	325 North Street , Bennington, Vermont, 05201

(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
F0812 SS = F	Continued from page 9 13.7-ounce bag of cheese queso that had expired on 6/12/25. An interview was conducted with Kitchen Staff Member #1 on 3/9/26 at approximately 11:40 AM. The Kitchen Staff Member confirmed these items were expired. He confirmed that the package of sausages and smart dogs were opened and unlabeled. Per observation of the kitchen on 3/11/26 at 9:01 AM there was one package of open and undated hot dog buns and two packages of hamburger buns with no date or initial. The package of sausages and smart dogs were still in the freezer. An interview was conducted with Kitchen Staff Member #2 on 3/11/26 at approximately 9:05 AM. Kitchen Staff Member #2 confirmed that these items should have been thrown away stating, “I’ll throw those away.” Per the facility’s “Dietary-Food Storage” policy [last revised 7/23] it states, “12. All Refrigerators and freezers will meet national sanitation foundation standards and will follow recommended temperatures. A. Temperature for freezer and refrigerator units will be monitored on a regular basis and equipped with a Fahrenheit thermometer which can easily be read. B. Elevated temperatures will be immediately brought to the attention of the Dietary manager or designee and environmental services." Per review of the facility’s freezer logs, on 2/8/26, the C wing freezer was recorded at 10 degrees F [Fahrenheit]. On 2/10/26, the North wing freezer temperature was recorded at 5 degrees F. On 2/11/26, the North wing freezer temperature was recorded at 5 degrees. On 2/12/26, the North wing freezer temperature was recorded at 5 degrees F. Per interview with the Food Service Coordinator on 3/11/26, at approximately 12:00 PM, the Food Service Coordinator confirmed that these temperatures for the freezer were elevated stating, “We tell maintenance about this and put a work order in.” The Food Service Coordinator confirmed that she did not submit the work orders for the freezers after these elevated temperatures were documented.	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Veterans' Home	**325 North Street , Bennington, Vermont, 05201**

(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
F0880 SS = D	Continued from page 10 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F0880	F880 Infection Prevention and Control The LPN was re-educated on proper hand hygiene during medication pass. Medication pass hand hygiene competencies were completed on all RNs and LPNS. Education on medicatin pass hand hygiene began on March 24, 2026 and will continue until complete. The RN Supervisor or designee will conduct 1 medication pass hand hygiene cometency per unit per shift weekly x 4 weeks, twice a month x 1 month and monthly x 1 month. Audit data will be reviewed at the monthly QAPI meeting. Audits will continue until the committee has determined sustained compliance has been achieved. The Chief Nursing Officers is responsible for compliance Complinace Date: April 25, 2026 **Tag F0880 POC accepted on 4/2/26 by W. White/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Veterans' Home	**325 North Street , Bennington, Vermont, 05201**

(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
F0880 SS = D	Continued from page 11 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that infection control measures regarding hand hygiene were followed during medication administration for two (Resident #1 and Resident #89) of 9 residents sampled. Findings include: During observation of medication administration on 3/11/2026 at 11:50 AM, there were 9 missed opportunities for proper hand hygiene. An LPN (Licensed Practical Nurse) did not use hand sanitizer or soap and water as required before or after wearing gloves, when preparing and administering medications, or when using and cleaning a glucometer (a device used to collect blood for measurement of glucose). The LPN failed to cleanse hands before and after glove use to: Prepare an oral medication for Resident #1Administer an oral medication to Resident #1Prepare eye drops and glucose testing for Resident #89Instill eye drops for Resident #89Test Resident #89's blood glucose level with a glucometer Cleanse the glucometer and dispose of used testing suppliesPrepare an insulin injectionAdminister insulin by injection to Resident #89Upon completion of the injection Per interview on 3/11/2026 at 12:05 PM, the LPN confirmed that hand hygiene should be performed before and after putting on gloves, direct contact with residents, preparing or handling medication, and visiting a resident's room, as well as after handling contaminated equipment (e.g., glucometer).	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Veterans' Home	**325 North Street , Bennington, Vermont, 05201**

(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
F0880 SS = D	Continued from page 12 Facility policy titled Hand Hygiene Policy (no review date) states that gloves do not replace hand washing/hand hygiene and that a hand sanitizer containing at least 62% alcohol will be used before preparing or handling medications, before and after direct contact with residents, and after removal of gloves.	F0880		