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

December 18, 2024

Lynne Stratton, Manager
Brookdale At Fillmore Pond
300 Village Lane
Bennington, VT 05201-9041

Dear Ms. Stratton:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 5, 2024.** 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.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0310	A. BUILDING: _____ B. WING _____	C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE AT FILLMORE POND	300 VILLAGE LANE BENNINGTON, VT 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) COMPLETE DATE
R100	Initial Comments: On 11/5/24 the Division of Licensing and Protection conducted an unannouced on-site annual re-licensure survey and investigation of 2 facility reported incidents. Findings include:	R100	Deficiency Statement Plan of Correction Attached	
R176 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure outdated medications are disposed of promptly. Findings include: The home's policies governing medications and treatments includes procedures for disposal of outdated medications. During the Memory Care Center medication cart review on the morning of 11/5/24 the following outdated medications were observed to be stored in the medication cart : a. Liquid Antacid expired 3/6/23 b .Vitamin D3 Gummies expired 9/2024 c. Vitamin B12 Nutritional Supplement expired 9/2024 d. 0.5 mg Lorazepam tablets expired on 10/21/24	R176		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynne Stratton | TITLE: Executive Director | (X6) DATE: 12/2/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0310	A. BUILDING: _____ B. WING _____	C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE AT FILLMORE POND	300 VILLAGE LANE BENNINGTON, VT 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) COMPLETE DATE
R176	Continued From page 1 These findings were confirmed by the Nurse on duty in the Memory Care Center at 11:09 AM on 11/5/24.	R176		
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure 4 out of 5 sampled staff	R179		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0310	A. BUILDING: _____ B. WING _____	C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE AT FILLMORE POND	300 VILLAGE LANE BENNINGTON, VT 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) COMPLETE DATE
R179	Continued From page 2 completed all required yearly trainings. Findings include: The home's policies and procedures governing staff trainings are consistent with this regulatory requirement. On the afternoon of 11/5/24 the Executive Director was requested to provide documentation of trainings completed for a sample of 5 staff. Per review of the staff training records provided for review, 4 out of 5 sampled staff did not complete all required yearly trainings. This finding was confirmed by the Executive Director at 5:22 PM on 11/5/24.	R179		
R190 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete criminal record and abuse registry checks as required for 3 out of 5 sampled residents. Findings include: The home's policies and procedures provided for review on request are not consistent with the regulatory requirements. At 10:18 AM on 11/5/24 the Executive Director was requested to provide documentation of criminal record and abuse registry background checks on file for a sample of 5 staff. Per review	R190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0310	A. BUILDING: _____ B. WING _____	C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE AT FILLMORE POND	300 VILLAGE LANE BENNINGTON, VT 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) COMPLETE DATE
R190	Continued From page 3 of the background checks provided for review, criminal record and abuse registry checks were not completed as required for 3 out of 5 sampled staff. This finding was confirmed by the Executive Director on the afternoon of 11/5/24.	R190		
R204 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.17 Death of a Resident 5.17.b In those deaths in which the medical examiner need not be notified, the manager shall: (1) Follow the instructions of the deceased, legal representative, if any, next of kin, or other relative regarding funeral and other related arrangements. (2) In instances where the services of an undertaker are not immediately available, and the resident occupied a multi-bed room, the manager shall arrange for the immediate removal of the body of the deceased resident to a separate unoccupied room. (3) Remove a deceased resident's body from the home within four (4) hours. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure the removal of a deceased resident's body within four hours of the resident's time of death for one applicable resident (Resident #1). Findings include: The home's policies and procedures governing death of a resident state the home will respond to the death of a resident in a manner which is guided by professional nursing standards of care.	R204		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0310	A. BUILDING: _____ B. WING _____	C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE AT FILLMORE POND	300 VILLAGE LANE BENNINGTON, VT 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) COMPLETE DATE
R204	Continued From page 4 Per record review Resident #1 passed away at the home while receiving end-of-life hospice care. Per Progress Notes, Resident #1 passed away at approximately 1:30 AM on 6/8/24. Upon the resident's death the home health agency providing hospice care for Resident #1 was notified by the home, and the staff on duty received a response from the home health agency indicating the agency would make an on-call visit to provide a pronouncement of death. Per information provided to the licensing agency regarding Resident #1's death, the home health agency did not arrive to pronounce the resident's death until 10:00 AM , which was followed by the funeral home's arrival at 1:20 PM. Per interview with the Executive Director on the afternoon of 11/5/24, the home health agency's delayed response resulted in a wait time of approximately 12 hours before Resident #1's body was removed from the home. Per interview on the afternoon of 11/5/24, the Executive Director confirmed the home was not aware the pronouncement of Resident #1's death was within the scope of practice of a Registered Nurse employed by the home, and confirmed the home's policy and procedures governing Death of a Resident do not prohibit the pronouncement of a resident's death by a Registered Nurse employed by the home. On the afternoon of 11/5/24 the Executive Director confirmed Resident #1's body was not removed from the home within 4 hours of the resident's time of death in accordance with licensing regulations.	R204		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0310	A. BUILDING: _____ B. WING _____	C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE AT FILLMORE POND	300 VILLAGE LANE BENNINGTON, VT 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) COMPLETE DATE
R250	Continued From page 5	R250		
R250 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.e The use of outdated, unlabeled or damaged canned goods is prohibited and such goods shall not be maintained on the premises. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure damaged canned goods are rejected and are not maintained on the the premises. Findings include: The home's policy and procedures governing dented cans are consistent with this regulatory requirement. Per observation during the facility tour commencing at 10:35 AM on 11/5/24 dented cans were observed to be stored with items to be served to residents in the in the emergency storage and dry goods storage areas of the home. Dented cans observed to be stored in the food service areas included 28 oz cans of roasted red peppers and #10 cans of beans, carrots, vanilla pudding, blueberry topping, and marinara sauce These findings were confirmed by the Director of Dining Services at 11:34 AM on 11/5/24.	R250		
R291 SS=F	IX. PHYSICAL PLANT 9.6 Plumbing	R291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0310	A. BUILDING: _____ B. WING _____	C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE AT FILLMORE POND	300 VILLAGE LANE BENNINGTON, VT 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) COMPLETE DATE
R291	Continued From page 6 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure water temperatures remained at or below 120 degrees Fahrenheit in resident accessible areas. Findings include: The home's policy and procedures governing water temperatures include temperature limits at or below 120 degrees Fahrenheit. During the facility tour commencing at 10:35 AM on 11/5/24 water temperatures were observed to be above 120 degrees Fahrenheit in the following areas of the home accessible to residents: a. Main Floor Bathroom 126.3 degrees F b. Main Floor Room #102 121.3 degrees F c. Memory Care Room #10 124.7 degrees F These findings were confirmed by the Executive Director and the Director of Maintenance during the facility tour on the morning of 11/5/24. Following adjustments to the home's water heating system by the facility's Maintenance Director water temperatures in areas previous identified were observed to be maintained at or below 120 degrees Fahrenheit.	R291		

Deficiency Statement Plan of Correction (POC)

Survey Date: November 5, 2024

Facility Name: Brookdale Fillmore Pond

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R176 5.10 R176 Plan of Correction accepted by Jo A Evans RN on 12/14/24	Outdated medications were immediately removed from the medication cart during survey.	11/5/24	The Health and Wellness Director, or designee, will perform weekly medication audits of all the medication carts in the building and document in a Medication Cart Audit Book that is to be kept in the HWD office. Any expired medications will be disposed of in accordance to Brookdale policy and state and federal regulations. Any expired medications will be re-ordered promptly to ensure that each resident receives the proper dose in accordance with physician orders.	The Executive Director will be responsible for the completion of this Plan of Correction.
R179 5.11 R 179 Plan of Corrections accepted by Jo A Evans RN on 12/14/24	Business Office Manager has run an updated report of trainings to be completed by staff members.	12/2/24	Business Office Manager will run a monthly report to ensure all required annual trainings are complete.	The Executive Director will be responsible for the completion of this Plan of Correction.
R190 5.12 R 190 Plan of Corrections accepted by Jo A Evans RN on 12/14/24	Business Office Manager has run updated background checks per the State of Vermont requirement for background checks.	12/2/24	Business Office Manager will keep a schedule of all staff member background checks and renew the required annual checks in a timely manner.	The Executive Director will be responsible for the completion of this Plan of Correction.
R204 5.17 R 204 Plan of Correction accepted by Jo A Evans RN on 12/14/24	Resident #1 no longer resides in the community.	12/2/24	The community's Death of a Resident policy states that associates (which includes caregivers, etc.) will respond according to state regulations in a respectful manner guided by nursing standards of care. It does not state that staff may or should declare death. The community's RNs are not trained to declare death and therefore may not do so pursuant to 11-1 of the nursing code. To address the deficiency, staff have been in-serviced on the requirement that a deceased resident's body must be removed from the home within four (4) hours. If hospice or other healthcare personnel authorized under state law to declare death do not come within two hours, community staff are to re-contact the hospice or healthcare provider and inform them to provide a	The Executive Director will be responsible for the completion of this Plan of Correction.

			person as soon as possible to declare death. If a declaration has not occurred within three and ½ hours, EMS will be contacted.	
R250 7.2 R 250 Plan of Corrections accepted by Jo A Evans RN on 12/14/24	The dented cans were removed and discarded immediately upon discovery.	11/5/24	The Dining Services Director, or designee, will ensure that cans are inspected upon delivery, and dented cans discovered after delivery will be marked with a large X and set aside so that they will not be used, per Brookdale policy.	The Executive Director will be responsible for the completion of this Plan of Correction.
R291 9.6 R 291 Plan of Corrections accepted by Jo A Evans RN on 12/14/24	Water temperatures were at or below 120 degrees Fahrenheit following adjustments to the water heating system.	11/5/24	On 11/8/24, we had an inspection of our mixing valve, and determined a moving spring in this valve needed replacement. The work has been scheduled with Bennington Cooling & Heating, we are waiting for the part to arrive. We have updated our TELS work order system, which prompts Maintenance to test three random areas per day, and these temps are recorded weekly in our TELS system.	The Executive Director will be responsible for the completion of this Plan of Correction.