

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

August 23, 2019

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

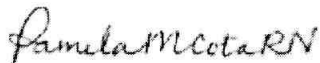
Provider ID #: 475032

Dear Ms. Jackson:

The Division of Licensing and Protection completed a survey at your facility on **August 21, 2019**. The purpose of the survey was to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare/Medicaid programs. This survey found that your facility was in substantial compliance with the participation requirements.

Congratulations to you and your staff.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

Enclosure

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

PRINTED: 08/22/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475032</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/21/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VERMONT VETERANS' HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>325 NORTH STREET BENNINGTON, VT 05201</b>
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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
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E 000	Initial Comments	E 000		
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An unannounced on-site emergency preparedness investigation was conducted by the Division of Licensing and Protection between 8/19 and 8/21/19. The facility was found to be in substantial compliance.

F 000	INITIAL COMMENTS	F 000		
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An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection between 8/19 and 8/21/19. The facility was found to be in substantial compliance.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.