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 8, 2024

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 survey conducted on **February 13, 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.

Sincerely,

PamelaMCotaRN
Pamela M. Cota, RN
Licensing Chief

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 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERMONT VETERANS' HOME	325 NORTH STREET 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) COMPLETION DATE
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced complaint investigation in conjunction with a facility reported incident (intake #22608 and #22580) on 2/12/24 - 2/13/24 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following deficiency was identified as a result of these investigations:	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Docusigned by: Melissa Jackson 7EA4D55658D145E...	CEO	3/7/2024

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.

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 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERMONT VETERANS' HOME	325 NORTH STREET 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) COMPLETION DATE
F 609	Continued From page 1 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to ensure that an allegation of staff to resident abuse was reported to the State Licensing Agency as required. Findings include: During an interview on 2/12/2024 at 2:30 PM Resident #1's significant other reported that she/he had placed a camera with no sound recording in Resident #1's room when visitation was being restricted due to COVID. The significant other stated that on 1/22/2022 while viewing the camera she/he witnessed a licensed nursing assistant (LNA) abuse her/his spouse. According to the significant other this allegation was not reported to the facility until 1/4/2023, on the same day an email was sent to the Deputy Administrator reporting the allegation. At this time the significant other was under the impression that the LNA was let go. On 12/5/2023 approximately one year after the initial allegation, while visiting Resident #1 she/he saw the LNA walk down the hall that Resident #1 resides in and realized that the LNA was allowed to return to work. Per the significant other she/he was very upset to see the LNA back and she/he sent another email to the Deputy Administrator asking how they could allow a known abuser to return to work. Per review of emails provided by the facility the Deputy Administrator, on 1/4/2023 Resident #1's significant other sent an email alleging that in the early evening of 1/22/2022 she/he witnessed a LNA holding the handles of Resident #1's wheelchair and proceeded to suddenly, rapidly,	F 609	The filing of this plan of correction does not constitute an admission of guilt. Vermont Veterans Home ("the Provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. F 609 Resident # 1 remains stable and has not had any negative outcomes for the event from December 2022. All allegations of abuse will be reported as required by regulations. This facility will ensure that all staff are competent in the regulatory requirements for abuse reporting. Staff education on abuse reporting will begin on March 11, 2024 and continue until completed. Random audits of staff competency will take place weekly x 4 weekly twice a month x 2 months and monthly x 3 months. Competency results will be reviewed at every other month QAPI meetings and will continue until the Committee validates sustained compliance. Compliance Date: March 29, 2024 **Tag F 609 POC accepted on 3/8/24 by S. Freeman/P. Cota**	

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 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERMONT VETERANS' HOME	325 NORTH STREET 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) COMPLETION DATE
F 609	Continued From page 2	F 609		

and abruptly, drop the wheelchair into a fully reclined position. This movement startled Resident #1 as evidenced by the resident shooting his/her hands out with palms up. The significant other alleged that the resident stated something like, "Hey! Take it easy!" and that the LNA stepped in front of the resident and in an angry pose, pointed his/her finger like S/he was scolding the resident. The facility did not report this incident to the licensing agency at the time. Approximately one year later on 12/5/23, after seeing the LNA in the hall, Resident #1's significant other sent another email to the Deputy Administrator asking how a known abuser of helpless defenseless residents could be allowed to return to work.

Per interview on 2/13/24 at 10:45 AM with the Deputy Administrator, S/he stated that when Resident #1's significant other reported this concern, the LNA was put on leave, and an investigation was completed by the Human Resource Department (HR). The Deputy Administrator confirmed that the allegation had not been reported to the State Licensing Agency.

During an interview on 2/13/24 at approximately 12:30 PM the facility Administrator confirmed that the 1/4/2023 or the 12/5/23 abuse allegations had not been reported to the State Licensing Agency. Per the Administrator the initial report made by Resident #1's significant other was considered a customer service or resident right issue, not an abuse allegation. The second allegation was not reported because it had been investigated by HR in the past and was found unsubstantiated.