| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475032 | A. Building<br>B. Wing | 01/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Vermont Veterans' Home | 325 North Street<br>Bennington, VT 05201 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50336<br><br>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 (Resident # 1). Findings include:<br><br>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.<br><br>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.<br><br>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. 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.<br><br>(continued on next page) |

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.

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

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Per the Facility assessment dated [DATE], 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 .<br><br>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.<br><br>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 wandering or entering other residents' rooms.<br><br>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.<br><br>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.<br><br>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.<br><br>51586<br><br>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 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].<br><br>Facility policy VVH [[NAME] 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.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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. |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29776<br><br>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.<br><br>Findings include:<br><br>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].<br><br>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.<br><br>Review of Res.#29's Behavioral Health Clinical assessment dated [DATE] 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:<br><br>-Summary of Current Mental Health or Psychiatric Issues<br><br>-History of trauma<br><br>-Type of trauma experienced<br><br>-Symptoms experienced<br><br>-Triggers<br><br>-Identified needs<br><br>-Recommended services/plan of care<br><br>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.<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>48017<br><br>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.<br><br>Per review of Resident #61's record, no evidence 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.<br><br>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. |

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| F 0790<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide routine and 24-hour emergency dental care for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29776<br><br>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.<br><br>Findings include:<br><br>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. 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.<br><br>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.<br><br>Review of Res. #26's Nutrition assessment dated [DATE] 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.<br><br>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. |