

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 Vermont Veterans' Home		STREET ADDRESS, CITY, STATE, ZIP CODE 325 North Street 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>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 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. F655Based on corrective actions completed prior to the onsite, this citation is designated as past non-compliance. The following actions were completed by the facility: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 (continued on next page)</p>

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 Level of Harm - Actual harm Residents Affected - Few	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.		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>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 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.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [ROOM NUMBER]. The room number signs were missing outside of rooms [ROOM NUMBERS], 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.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [NAME] 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 [NAME] 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 [NAME] Unit on 3/10/26 at 7:54 AM the medication cart was found unlocked. Per interview with RN Unit Manager of the [NAME] 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. 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 trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with diagnoses that included nicotine dependence and respiratory failure. A smoking assessment dated [DATE] 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 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)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>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 #1 Administer an oral medication to Resident #1 Prepare eye drops and glucose testing for Resident #89 Instill eye drops for Resident #89 Test Resident #89's blood glucose level with a glucometer Cleanse the glucometer and dispose of used testing supplies Prepare an insulin injection Administer insulin by injection to Resident #89 Upon 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). 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.</p>		