VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

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

April 22, 2026

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 **March 31, 2026**. 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 _____	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE AT FILLMORE POND	300 VILLAGE LANE BENNINGTON, VT 05201

R159, R210, R225, R358, and R403
Accepted April 22, 2026
Susan Canas Gregoire RN

(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 An unannounced, on-site, relicensure survey was conducted by the Division of Licensing and Protection on March 31, 2026. The following regulatory violations were identified:	R100	Please see attached Plan of Correction	
R159 SS=D	5.9.c (2) Nursing Services For each resident requiring a nursing overview, administration of medication, or nursing care, the registered nurse must: Develop a person-centered written plan of care within 14 days after admission, in accordance with the nursing process and professional standards of practice, for each resident that is based on abilities and needs as identified in the resident assessment. The resident, and if the resident chooses, resident representatives such as family or close supports, must be invited and allowed to participate in care planning meetings. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being, and must be revised as the resident?s abilities and needs change This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to ensure the development and ongoing revision of a person-centered written plan of care that identified resident-specific goals and interventions as required by state rules, for one applicable Resident (Resident #1). Findings include:	R159		

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R159	Continued From page 1 The home's Residency Agreement under the section titled " Personal Service Plan," states that prior to moving in and periodically throughout the residency we will use a personal service assessment to determine the personal services you require and the personal service assessment will be used to develop your personal service plan. The home's Memory Care Neighborhood Policy, titled "Assessment and Reassessment Changes in Condition" states the assessments will be conducted annually and whenever there is a change in mental or physical condition to ensure that the facility meets each resident's care needs in an efficient manner. The home's registered nurse job description, under the section titled " Essential Functions," states that the registered nurse documents all pertinent information related to nursing care plans, observation of the resident's overall condition and behavior, medical record documentation, and admission, discharge, and patient teaching. Per record review of documented progress notes, conducted on the afternoon of March 31, 2026, Resident #1 resides in the home's memory care unit and has cognitive impairment with noted decline in physical functioning. Progress notes document episodes of agitation for which as-needed (PRN) medication was administered on multiple occasions. Notes further described staff assistance with toileting, including instances of refusal of care. Additional documentation indicates that Resident #1 is receiving hospice services. Per observation during the facility tour conducted	R159		

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R159	Continued From page 2 on the morning of March 31, 2026, Resident #1's room was observed to have a strong, persistent odor. The condition of the room was consistent with concerns related to urinary incontinence. Per record review conducted on March 31, 2026, Resident #1's current person-centered written plan of care did not address identified care needs. The plan did not include interventions related to management of agitation or associated medication administration, did not address toileting or incontinence needs, and did not reflect the Resident's status as receiving hospice services or having a terminal condition. Review further indicated that the care plan had not been revised since November 18, 2025. These findings were acknowledged by the Registered Nurse on the morning of March 31, 2026	R159		
R210 SS=F	5.11.c Staff Services The home must provide, or arrange for the provision of, at least twelve (12) hours of training upon hire and each year to each staff person providing direct care to residents. The manager may give credit towards the required 12 hours of training upon hire, for any formal training received in the twelve months preceding the date of hire, provided the home maintains documentation of the training and ensures competency in the subject matter. 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	R210		

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R210	Continued From page 3 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, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; (7) General supervision and care of residents; (8)Communication strategies, person-centered care, challenging behaviors and understanding dementia; (9) Recognition of and sensitivity to different cultures, belief systems, abilities, gender identities, sexual orientation; and (10) Trauma-informed care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure required staff training was completed for two of seven sampled staff. Findings include: The facility's Vermont Training Plan Checklist and its staff training policies are consistent with licensing rules. Per record review conducted on the morning of March 31, 2026, training documentation for seven sampled staff was reviewed. Review of the documentation provided indicated that two direct care staff lacked evidence of completion of required training. These findings were acknowledged by the Manager on the afternoon of March 31, 2026.	R210		

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R225 SS=F	5.12. b (4) Records/Reports The home must keep and maintain the following records: 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 interviews and record review, the licensee failed to ensure that required criminal record and abuse registry background checks were completed as required for two of seven sampled staff. Findings include: The licensee's "Criminal Background Check" policy is consistent with state licensing rules. On March 31, 2026, documentation of criminal record and abuse registry background checks maintained at the home was reviewed for a sample of seven staff. Record review indicated that required background checks had not been completed as required for two of the seven sampled staff. This finding was confirmed by the Manager of the home on the afternoon of March 31, 2026.	R225		
R358 SS=F	6.10 Resident's Rights The resident's right to privacy extends to all records and personal information. Personal information about a resident must not be discussed with anyone not directly involved in the resident's care. Release of any record, excerpts from or information contained in such records are subject to the resident's written approval, except as requested by representatives of the licensing	R358		

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R358	Continued From page 5 agency to carry out its responsibilities or as otherwise provided by law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure residents' right to privacy related to resident records, including private health information. Findings include: The licensee's "Residents' Rights Policy" posted in a common area of the home states that the residents' right to privacy extends to all records and personal information. Per observation during a facility tour conducted on the morning of March 31, 2026, a third-floor storage closet located in a common hallway used by residents, visitors, guests, and staff was observed to be unlocked and unattended. Resident records and documentation containing protected health information were observed to be accessible within the area. Accessible materials included, but were not limited to, documents containing resident names and diagnoses, resident charts, monitoring and discharge planning documentation, health assessments, resident photographs, and medication administration records. Per continued observation during the facility tour conducted on the morning of March 31, 2026, an unlocked cabinet located in the common living room of the home's special care unit was observed to contain resident charts. The resident charts contained admission records, assessments, plans of care, and new resident intake documentation, all of which included	R358		

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R358	Continued From page 6 resident-identifiable and confidential medical information. These records were maintained in an unsecured manner and were observed to be accessible to residents, visitors, and other unauthorized individuals. These findings were acknowledged by the Manager on the afternoon of March 31, 2026.	R358		
R403 SS=F	9.1.c Environment The home must ensure that the resident environment remains as free of accident hazards as possible. Maintaining a safe environment must include the safe storage and clear labeling of chemical agents, which must include secure storage of such agents if the home has residents with cognitive impairment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the licensee failed to ensure that the resident environment remained as free of accident hazards as possible, including the safe and secure storage of chemical agents in a home with residents, including those who have cognitive impairment. Findings include: The home's "Chemical Labeling, Container Storage, and SDS Requirements" Policy states that chemicals should never be left unattended. The home's "Key Policy" states that it is the responsibility of each worker to properly secure all keys issued to them for access to data facilities. Lost or stolen keys must be reported promptly, and the key holder must store keys in a	R403		

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R403	Continued From page 7 way generally guaranteeing protection from unauthorized use. It is unacceptable to store keys in common or generally accessible areas. The home's "Physical Environment Safety" policy states that knives, matches, firearms, tools, and other items that could constitute a danger to residents including cleaning supplies and disinfectants should be stored inaccessible to residents with dementia. During the facility tour conducted on the morning of March 31, 2026, multiple chemical products were observed stored in an unsecured manner. In a common sitting area, a cabinet located under the sink was observed to contain multiple bottles of chemicals including, but not limited to, floor cleaner, pet stain remover, window cleaner, bathroom cleaner, disinfectant, and nail polish remover. The cabinet was unsecured and accessible to residents with cognitive impairment. Per additional observation on the morning of March 31, 2026, in multiple resident rooms additional chemicals were observed to be stored in an unsecured manner including but not limited to furniture polish, insecticide, glass cleaner, and other cleaning agents. Through continued observation during the facility tour on the morning of March 31, 2026, keys are observed to be unsecured in two separate common areas of the home, including areas accessible to residents with cognitive impairment. In each location a key on a lanyard attached to a medication cart was observed to be accessible. Per staff interview, on the morning of March 31, 2026, the Maintenance Manager indicated that these keys were used to unlock resident room doors within the facility.	R403		

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R403	Continued From page 8 Further observation conducted during the facility tour on the morning of March 31, 2026, indicated that a set of nurse's keys was observed unattended on a countertop in the home's special care unit and was accessible to residents with cognitive impairment. These keys provided access to multiple secured areas within the facility. During the facility tour conducted on the morning of March 31, 2026, the maintenance room door was observed open and accessible from a common area of the home. Inside the room, multiple tools and maintenance items were observed stored in an unsecured manner, including, but not limited to, sharp tools, nails, wiring, tubing, and mechanical equipment associated with the home's utility systems. These findings were acknowledged by the Manager on the afternoon of March 31, 2026.	R403		

Deficiency Statement Plan of Correction (POC)

Survey Date: **March 31, 2026**

Facility Name: **Brookdale Fillmore Pond**

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R159, 5.9c	The personal service plan for Resident #1 has been reviewed by the current Health and Wellness Director. The goals and interventions have been updated accordingly with a completion date of 4/1/26.	The Health and Wellness Director, Health and Wellness Coordinator and nursing designees will conduct a comprehensive review of all current resident's Personal Service Plans to verify that the appropriate interventions are in place. Targeted date for completion is 5/15/26.	4/1/26	The Health and Wellness Director will continue to monitor for ongoing compliance through the community's bi-weekly Collaborative Care Review. In addition, all clinical personnel have a copy of Brookdale's PL.6-017 Change of Condition policy for their review and signature with a completion date of 4/16/26. A clinical in-service was completed on 4/15/26.	Health and Wellness Director and Executive Director R159 Accepted April 22, 2026 Susan C Gregoire RN
R210, 5.11c	The 2 associates that had not completed the annual in-services were addressed on 3/31/26. One has completed all trainings, the other has several more and will have them completed by 4/30/26.		4/30/26	Business Office Manager will run a monthly report to ensure all required annual trainings are complete.	Business Office Manager and Executive Director R210 Accepted April 22, 2026 Susan C Gregoire RN
R225, 5.12	National background checks were completed for the 2 associates that were sampled during survey. One of those 2 associates had one completed by corporate	All national background checks being run on associates hired before 1/1/23. All associates hired after that date are complete.	4/30/26	The Business Office Manager is auditing all associate records and requesting National background checks on any that were not re-done in 2023. National background	Business Office Manager and Executive Director R225 Accepted April 22, 2026 Susan C Gregoire RN

	Brookdale on 12/26/25. The other was completed 4/16.26.			checks done after 1/1/23 have been completed upon hire.	
R358, 6.10	The 3rd floor storage room door now has self-closing hinges with a key pad for entry. The door will automatically lock each time it closes. The special care unit cabinets containing resident charts now have locks on them.	There are no other storage areas that fall in to this category.	4/14/26	Storage area and resident charts on special care unit are now locked.	Executive Director R358 Accepted April 22, 2026 Susan C Gregoire RN
R403, 9.1	An audit was conducted of the "country kitchen" cabinets and the resident rooms. All chemicals have been removed and placed in a secured area not accessible to residents. All med cart keys are on lanyards and are worn by the med tech or nurse on that cart for that shift. No master key is available in any accessible area, and is kept in the locked nurses' area. The Maintenance Office now has self-closing hinges with a keypad lock. Each time the door closes it will automatically lock.	A community audit was completed to evaluate for unsecured safety hazards and none were found.	4/1/26	All associates educated on key security and protection, and safe chemical storage. Additional education provided at survey review at all staff meeting 0n 4/15/26. Brookdale in-services also educate on chemical safety.	Executive Director R403 Accepted April 22, 2026 Susan C Gregoire RN