



Department of Disabilities, Aging and  
Independent Living  
Division of Licensing and Protection  
280 State Drive/HC 2 South  
Waterbury, VT 05671-2060  
[www.dlp.vermont.gov](http://www.dlp.vermont.gov)

[phone] 802-241-0344  
[fax] 802-241-0343

AGENCY OF HUMAN SERVICES

December 10, 2025

Ms. Tabitha Davis-Barron, Administrator  
Bennington Health & Rehab  
2 Blackberry Lane  
Bennington, VT 05201

Provider ID #: 475027

Dear Ms. Davis-Barron:

The Division of Licensing and Protection conducted an onsite complaint investigation on **November 25, 2025**. The purpose of the investigation was to determine if your facility was in compliance with Federal participation requirements of the Medicare/Medicaid Program. The investigation was completed on **November 25, 2025**, and there were no regulatory violations related to the complaint allegations.

Sincerely,

A handwritten signature in cursive script that reads "Pamela M. Cota RN".

Pamela M. Cota, RN, BS  
Assistant Division Director  
State Survey Agency Director

Enclosure

|                                                                      |                                                                                                                                                                                                                                                                                                                          |                                                                        |  |                                                                                                |                                                                                                                          |                                                 |                            |
|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>         |                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>475027</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                           |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>11/25/2025</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>Bennington Health &amp; Rehab</b> |                                                                                                                                                                                                                                                                                                                          |                                                                        |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2 Blackberry Lane , Bennington, Vermont, 05201</b> |                                                                                                                          |                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                             |                                                                        |  | ID<br>PREFIX<br>TAG                                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                 | (X5)<br>COMPLETION<br>DATE |
| F0000                                                                | INITIAL COMMENTS<br><br>The Division of Licensing and Protection conducted an unannounced, onsite investigation of 3 complaints #2663649, 2626146, & 2663873 on 11/25/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. No deficiencies were cited as a result of this survey. |                                                                        |  | F0000                                                                                          |                                                                                                                          |                                                 |                            |

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 reverse for further 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 |
|-----------------------------------------------------------------------|--|-------|-----------|