VERMONT

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

January 8, 2026

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

Provider ID #: 475027

Dear Ms. Davis-Barron:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **December 10, 2025.** 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,

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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475027	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bennington Health & Rehab	2 Blackberry Lane , Bennington, Vermont, 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
E0000	Initial Comments The Division of Licensing and Protection conducted an annual emergency preparedness survey on 12/10/25. The facility was found in substantial compliance with emergency preparedness regulations.	E0000	The filing of this plan of correction does not constitute any admissions as to any of the alleged violations set forth in this statement of deficiencies. The plan of correction is being filed as evidence of the facility's continued compliance with all applicable laws and the facility's desire to continue to provide quality services.	
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey, in addition to two complaints (2594289 and 2653243) and one facility reported incident (2604525), from 12/8/25 through 12/10/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F0000		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure that residents who require dialysis receive services consistent with professional standards of practice and the comprehensive, person-centered care plan for one of one residents (Resident #5). Findings include: Per record review, Resident #5 was admitted to the facility on 10/6/25 with diagnoses that included end stage renal disease, anemia in chronic kidney disease, and dependence on renal dialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys cannot). The Resident has a central venous catheter (a soft plastic tube, tunneled under the skin and placed in a vein in the neck, chest, or groin, which enters a central vein	F0698	1. Resident #5 had a smooth clamp placed in bedside E-kit 2. All residents who have a central venous catheter have the ability to be affected by this alleged deficient practice. All residents who have a central venous catheter had the E-kit checked to ensure there was a smooth clamp in it. 3. All Nurses will be educated on the dialysis policy which includes which items should be included in the E-kits 4. Audits of E-kits will be completed weekly x4 and then monthly x3 by DNS(or designee) or until substantial compliance is achieved starting on 1/9/26. Results of audits will be discussed at QAPI. 5. The DNS will be responsible for this plan of correction **Tag F 698 POC accepted on 1/8/26 by J. Kendall/S. Stem**	1/2/26

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
LNHA	Administrator	12/30/25

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F0698 SS = D	Continued from page 1 that leads to the heart). Review of Resident #5's Care Plan reveals a Focus area for the Resident is at "risk for worsening impaired renal function and is at risk for complications related to hemodialysis," which was initiated on 10/7/25. One of the interventions listed is to "maintain smooth catheter clamps at the bedside (and on patient when out of bed) in case of breakage or excessive bleeding from catheter," which was also initiated on 10/7/25. During observations on 12/8/25 at 1:00 PM, no smooth clamps were located at the bedside in Resident #5's room. Per interview on 12/9/25 at 2:30 PM with the Unit Manager (UM), she stated that the Resident should have an "Emergency Kit" at the bedside, including the smooth clamps. The UM then asked one of the nurses to check the kit for the clamps. He returned and stated the kit was at the bedside but didn't include the clamps. During an observation on 12/9/25 at 3:16 PM with the Director of Nursing (DON) and the UM, the kit in Resident #5's room didn't include the needed smooth clamps. The DON confirmed again that the clamps need to be added and that the emergency kit should be with the Resident at all times, including when they are off-site for dialysis. Reference National Kidney Foundation. 2023, January 1. Dialysis (https://www.kidney.org/kidney-topics/dialysis) MedlinePlus. 2024, October 28. Daily assessment of the vascular access site is necessary to avoid infection, blood clots, and other problems. (https://medlineplus.gov/ency/patientinstructions/000591.htm) The American College of Surgeons. 2017. What is a Central Venous Access Device (CVAD)? (https://www.facs.org/media/2tcnbb4f/understanding_your_central_line.pdf)	F0698		
F0773 SS = D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance	F0773	1.Resident #6's labs were immediately drawn and ordered stat. Results were reported to Physician. 2.Any resident who has lab work ordered and not obtained has the ability to be affected by this alleged deficient practice. Lab orders were audited for the last 30 days to ensure all labs ordered were obtained and physician notified if necessary.	

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F0773 SS = D	Continued from page 2 with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to provide or obtain laboratory services when ordered by a physician; and/or notify the physician when ordered labs were not completed for one resident [Resident #6] of 29 sampled residents. Findings include: Per review of Resident #6's medical record, a "third eye health note" [a telemedicine service which examines patients remotely via video and audio] dated 11/25/25 reveals the resident was "seen for new-onset gross hematuria [where blood is visible in the urine]. [H/she] is noted to be on Eliquis [an anti-blood clotting medication] with no reports of hematuria in the past (although [h/she] was recently hospitalized for a Gastro-Intestinal Bleed two times in September and October)." According to the Mayo Clinic, the healthy range for hemoglobin is: For men, 13.2 to 16.6, for women, 11.6 to 15. [Hemoglobin (abbreviated Hgb or Hb) is the protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues]. The telemedicine note continues: "Recent Hgb levels [for Resident #6]: 8.2 on 11/13/25 10.9 on 10/9/25 Diagnosis, Assessment/Plan: - Gross hematuria (Primary). This is an acute new problem. Condition is worsening. Will hold AM Eliquis [anti blood clotting medication] if recurrent hematuria overnight and check CBC in A.M. [A complete blood count (CBC) is a blood test that measures amounts and sizes of red blood cells, hemoglobin, and other blood components]."	F0773	F0773 continued 3.All Nurses will be educated on the proper way to enter labs into the resident chart to ensure that they show up on the MAR so they are obtained in the time frame as ordered. 4. An audit will be completed of all lab orders entered by DNS(or designee) to ensure ordered labs were obtained. This will be done weekly x4 then monthly x3 or until substantial compliance is achieved starting on 1/9/26. Results of audits will be discussed at QAPI. 5.DNS will be responsible for this plan of correction **Tag F 773 POC accepted on 1/8/26 by J. Kendall/S. Stem**	1/2/26

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F0773 SS = D	Continued from page 3 Review of Physician Orders for Resident #6 on 11/25/26 include "Hold A.M. Eliquis for recurrent hematuria overnight - Check CBC/BMP [BMP (basic metabolic panel) is a test that measures several important aspects of blood, like electrolytes and blood sugar]. - Notify a clinician of any change in condition." Further review of Resident #6's medical record revealed no documentation that the Physician Order for CBC dated 11/25/25 was completed as ordered, and/or results obtained and the physician notified. An interview was conducted with the Director of Nursing [DON] on 12/9/25 at 4:42 PM. The DON confirmed that the Physician Order for labs for Resident #6 were never completed and/or the physician notified. The DON reported an order for the CBC was entered and completed after the interview with the surveyor on 12/9/25. Review of "Change of Condition" notes for Resident #6 on 12/9/25 regarding the newly completed labs reveal "lab critical value reported by [hospital] lab for 7.8 hemoglobin down from 8.2 from previous lab." Resident #6's Physician responded by ordering a test for blood in the stool and to repeat the CBC blood work in two days.	F0773		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve	F0812	1.All items that were not labeled or were outdated were disposed of. 2.Any resident who consumes food made by the kitchen has the ability to be affected by this alleged deficient practice.An audit of the kitchen storage area/walk in cooler and refrigerators on the units was completed. Any outdated or unlabeled food was immediately disposed of. 3.Dietary staff were educated on the food storage/labeling policy. 4.An audit of the kitchen's labeling/dating checklist will be completed by the Administrator (of designee) weekly x4 and then monthly x3 or until substantial compliance is achieved, starting on 1/9/26. Results of audits will be presented at QAPI. 5.The Administrator will be responsible for this plan of correction. **Tag F 812 POC accepted on 1/8/26 by J. Kendall/S. Stem**	1/2/26

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F0812 SS = F	Continued from page 4 food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and policy reviews, the facility failed to store food in accordance with professional standards for food service safety. This deficiency has the potential to impact all residents in the facility. This is a repeat deficiency for this facility, with the violation cited during a previous partial survey dated 7/16/25. Findings include: 1. Per the initial tour of the Kitchen on 12/8/25 at 10:49 AM, a rack containing dishware was revealed. The Dietary Manager stated the dishware was ready for use. There was half a tray of cups that had been flipped upside down and were observed to be wet on the sides, and the bottoms of each cup. The Dietary Manager confirmed the cups were ready for use but hadn't been dried correctly. The Dietary Manager stated the cups should've remained on a drying rack to allow air to circulate and complete the drying process. The tour of the dry storage area revealed an open brownie mix and a package of elbow pasta with no dating. The Dietary Manager confirmed that both items should have labels indicating the dates they were opened. The refrigerators revealed one pitcher of a yellowish fluid that the Dietary Manager stated was lemonade, a red substance in a clear, square container with a lid that the Dietary Manager stated was cranberry sauce, shredded vegetables with dressing in a clear, square container that the Dietary Manager stated was coleslaw, and diced, beige product which the Dietary Manager stated was diced chicken that were not labeled with what the items were or dates of production or expiration. The Dietary Manager confirmed that all items should be labeled with the item name, the date they were placed in the refrigerator, and the date they should be disposed of. Eleven packages of flour tortillas expired on 11/21/25, and a clear, square container of marina expired on 11/14/25. The Dietary Manager confirmed that expired items should be removed and disposed of, not left in storage. She showed signage posted on the refrigerators indicating the task of labeling and dating items. The freezer revealed an open ravioli package that wasn't dated, and a box of hamburger patties was open to the air and not dated. The Dietary Manager confirmed that the items should be dated and stored in closed	F0812		

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F0812 SS = F	Continued from page 5 containers to protect their integrity per policy. 2. A tour of the Kitchen on 12/10/25 at 1:15 PM with the Chef revealed an open, undated egg substitute carton in the refrigerator, which he confirmed should be dated when the seal is broken. The Chef was shown a picture provided by a resident showing a hot dog bun with a green-gray discoloration. He confirmed he was aware of the "moldy bread," stating that the Kitchen was contacted during service on the day it was served, and the Kitchen staff remade the Resident's meal. The Chef said, "It has been a struggle to balance the stock of bread," as the freezer space is limited. 3. Per review of a facility policy "Date Marking" (dated 9/11/2020), states "Date Marking systems are in place to reduce foodborne illness caused by, Listeria monocytogenes (a type of disease-causing bacteria which can have mild symptoms such as fever, muscle aches, nausea, vomiting, and diarrhea or more severe symptoms may include headache, stiff neck, confusion, loss of balance, and convulsions, FDA 1/16/25), a pathogen that continues to grow in refrigerated temperatures." The policy continues to state, "Foods will be date marked with the name of the product, the date of production or opening. Refer to Quick Reference List (reference list of shelf lives of products) for discard date." Per interview on 12/10 at 3:54 PM, the Dietary Manager confirmed that the practice and facility policy require that items in storage be covered or placed in a container, labeled, and dated. Reference https://www.fda.gov/food/foodborne-pathogens/listeria-listeriosis 1/8/2026 POC accepted by Jane Kendall	F0812		