VERMONT

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

[phone] 802-241-0344
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AGENCY OF HUMAN SERVICES

July 27, 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 complaint investigation conducted on **June 30, 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.

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 06/30/2026

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
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of five complaints and one facility reported incident, including reports #2692520, #2703901, #2794806, #2807539, #2961590 and #3010482 on 6/30/26 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiency was identified:	F0000	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.	
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, and record reviews, the facility failed to ensure that each resident receives adequate supervision to maintain safety and prevent elopement for 1 or 1 sampled residents (Resident #1). Findings Include: A progress note dated 4/30/26 stated that Resident #1 left the facility on an unauthorized leave of absence. A document completed by the facility titled: “Elopement Drill Documentation form” stated Resident #1 was identified missing at 9:42 PM. Resident #1 was located by Bennington Police Department at their partners apartment and returned to facility at 10:12PM. Per record review, Resident #1 has a Brief Interview for Mental Status (BIMS) score of 14. (BIMS is a standardized cognitive screening tool used primarily in long-term care and skilled nursing facilities to	F0689	1.Resident #1 returned to the facility safely and suffered no i ill effect from the event. 2.Residents that have eloped are at risk due to this alleged deficient practice. An initial audit will be completed of the last two weeks to ensure residents have received adequate supervision and elopement has been prevented. 3.Facility staff will be educated on proper supervision of residents who may be an elopement risk in order to maintain safety and prevent elopements. 4.Audits will be performed to ensure residents receive adequate supervision to maintain safety and prevent elopement weekly for 4 weeks starting on 8/7/26. Then monthly for 3 months until substantial compliance has been achieved. Results of the audits will be discussed at QAPI. 5.The DNS will be responsible for this POC. **Tag F0689 POC accepted on 7/27/26 by W. White/S. Stem**	7/31/26

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
Jakota Hawks	Administrator	7/23/26

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F0689 SS = D	Continued from page 1 assess a resident's memory, thinking, and orientation skills. A score of 14 indicates intact cognitive function). Resident #1's care plan indicates that they can ambulate independently with a walker or wheelchair and are at risk for falls. Per interview with Resident #1 on 6/30/26 at 8:32 AM, s/he stated they left the facility in a hurry because they were concerned about their spouse when they learned their spouse was in hospital. Resident #1 confirmed they did not utilize the facility's protocol for a leave of absence because they did not have a ride and they were not thinking clearly. Resident #1 confirmed they walked with their walker to the apartment complex where their spouse lives approximately 0.7 miles from the facility. Resident #1 stated it took a very long time to get there. Bennington Police Department arrived and brought Resident # 1 back to the facility. Per interview with Physical Therapist #1 on 6/30/26 1:45 PM, they stated that Resident #1 does have balance issues, poor safety awareness, and frequently becomes short of breath with ambulation. Per interview with the Communications Specialist at Bennington Police Department on the morning of 6/30/26, they read from a police report of the elopement that a call came in at 9:30 PM on 4/30/26. It was reported that Resident #1 had eloped from the facility. The facility reported they had last seen Resident #1 30 minutes prior to the call. The resident had gone to the spouse's house. Between 10:02PM and 10:07 PM Bennington Police found Resident #1 and returned them to the facility. Per interview with the Administrator on 6/30/26 at approximately 11:15 AM, the facility was unaware that Resident #1 had left facility grounds at the time of their departure. Resident #1 is their own person who on occasion uses the facility's leave of absence pass to go out with a friend or family. The Administrator confirmed they reviewed the camera footage from 4/30/26 and Resident #1 exited through the front door as a visitor was entering and went to the right of the building. The Administrator confirmed the footage did not show Resident #1 entering a vehicle. The Administrator confirmed Resident #1 should not have been able to exit the facility without staff knowing. The facility has a 24 hour 7 days a week receptionist at the front door and the front door locks at 8:00PM. Some family members have the code to enter the building. At approximately 12:35 PM she confirmed they may not have remembered the exact time the resident departed when reviewing the facility's camera	F0689		

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F0689 SS = D	Continued from page 2 footage.	F0689		

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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,

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

Vermont Division of Licensing and Protection

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S0000	Initial comments The Division of Licensing and Protection conducted an unannounced, onsite investigation of five complaints and one facility reported incident, including reports #2692520, #2703901, #2794806, #2807539, #2961590 and #3010482 on 6/30/26 to determine compliance with Vermont Licensing and Operating Rules for Nursing Homes. The following regulatory deficiency was identified:	S0000	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	
S208 SS = D	REPORTS TO LICENSING AGENCY CFR(s): 2.9 (a - d) The following reports must be filed with the licensing agency: 2.9 (a) At any time a fire occurs in the facility, regardless of the size or damage, the licensing agency and the Department of Labor and Industry must be notified by the next business day. A written report must be submitted to both departments by the next business day. A copy of the report shall be kept on file in the facility. 2.9 (b) Any untimely death that occurs as a result of an untoward event, such as an accident that results in hospitalization, equipment failure, use of restraint, etc., shall be reported to the licensing agency by the next business day, followed by a written report that details and summarizes the event. 2.9 (c) Any unexplained or unaccounted for absence of a resident for a period of more than 30 minutes shall be reported promptly to the licensing agency. A written report must be submitted by the close of the next business day. 2.9 (d) Any breakdown or cessation to the facility's physical plant that has a potential for harm to the residents, such as a loss of water, power, heat or telephone communications, etc., for four hours or more, shall be reported within 24 hours to the licensing agency. This LICENSURE REQUIREMENT is NOT MET as	S208	1.Resident #1 returned to the facility Safely and suffered no ill effect from the event. 2.Residents that have eloped are at risk due to this alleged deficient practice. An initial audit will be completed of any residents who have had an unauthorized LOA within the last two weeks to ensure elopement was reported if the reporting guidelines were met. 3.The Administrator, DNS and ADNS will be educated on state regulations for reporting to the licensing agency. 4.Audits will be carried out to ensure that any unauthorized LOA will be reviewed to ensure that facility reports an elopement to the licensing agency if within the reporting requirements. This will be done weekly x 4 weeks starting on 7/31/26. Then monthly x 3 months or until substantial compliance is achieved. The results of the audits will be discussed at QAPI. 5.The administrator will be responsible for this plan of correction. **Tag S208 POC accepted on 7/27/26 by W. White/S. Stem**	7/27/26

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jakita Hamilton	Administrator	7/23/26

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S208 SS = D	Continued from page 1 evidenced by: Based on record review and interview, the facility failed to report an elopement to the licensing agency. Findings include: Per review of an "Elopement Drill Documentation" form, Resident #1 had eloped from the facility on 4/30/26. While this form documents that Resdeint #1 was known to be missing for 30 minutes, it does not identify how long Resident #1 had been out of the facility prior to identifying the elopement. There is no evidence that the licensing agency was notified of the elopement or that a written report was sent. Per interview with the Communications Specialist at Bennington Police Department on the morning of 6/30/26, they read from a police report of the elopement that a call came in at 9:30 PM on 4/30/26. It was reported that Resident #1 had eloped from the facility. The facility reported they had last seen Resident #1 30 minutes prior to the call. The resident had gone to the spouse’s house. Between 10:02PM and 10:07 PM Bennington Police found Resident #1 0.7 miles away from the facility at night and returned them to the facility. This revealed that the resident had been missing from the facility for over 30 minutes. Per interview with the on 6/30/26 at approximately 12:35 PM the Administrator confirmed the facility did not report an elopement to the licensing agency.	S208		