VERMONT

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

August 5, 2026

Ms. Meaghan Mosso, Administrator
Center for Living & Rehabilitation
160 Hospital Drive
Bennington, VT 05201

Provider ID #: 475029

Dear Ms. Mosso:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **July 13, 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: 475029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center for Living & Rehabilitation	160 Hospital Drive , 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 commenced an unannounced, onsite investigation of one complaint #3045713 and one FRI #3066805 (facility reported incident) on 7/6/26 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. On 7/8/26, the survey team identified and notified the facility of a deficiency at the Immediate Jeopardy (IJ) level for F0689, related to violations around accident hazards and supervision. On 7/13/26, an onsite visit to assess the removal of the immediate jeopardy was conducted and the facility had completed sufficient corrective actions to remove the immediate jeopardy by reassessing all residents in the facility who are a fall risk modifying their care plans, and reassigning the rooms on the separate hallway to the closer unit where the call bells alert the staff assigned to their care, with a removal date of 7/9/26. Non-compliance with the requirements at F0689 remain. The facility is licensed for 145 beds and had a census of 123 at the time of the survey. During the complaint survey, the survey team identified substandard quality of care as a result of a violation at F0689 Free from Accident Hazards / Adequate Supervision / Assistive Devices. An onsite extended survey was conducted on 7/13/26 due to the determination of substandard quality of care, with no additional findings identified.	F0000	F689 Free of Accident Hazards/Supervision/Devices What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility could not retroactively correct the deficiency as it relates to Resident #1. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? An audit of the fall risks evaluation scores for all residents was conducted. Fall risk evaluations were updated as indicated. The corresponding care plans were reviewed and updated as indicated. Environmental audit was conducted to review implementation and placement of fall prevention devices. Residents in the 3 rooms noted were reassigned (one room is vacant). An audit of all residents was conducted to identify those with repeat falls in the past 3 months. Residents with repeat falls were reviewed by the IDT team for root cause analysis and fall prevention planning. Further updates to their plan of care were identified and implemented as indicated. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	
F0689 SS = SQC-J	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:	F0689	The following policies: "Routine Resident Checks"; "Safety Checks-CLR"; "Accidents and Incidents"; "Fall Prevention and Protocol", "Fall Risk Evaluation Tool", "Plan of Care" and "Interdisciplinary(IDT) Plan of Care (POC) Document" were reviewed and updated as indicated. Education was provided to all nurses regarding the process for completing the Fall Risk Evaluation. Education was provided to all RN supervisors/managers regarding post fall procedures, root cause analysis, and care planning. Education was provided to all staff regarding falls and fall prevention. The three rooms identified were assigned to the hallway where the call light indicator is located.	

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
Maryn T Mun	Administrator	7/31/2026

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F0689 SS = SQC-J	Continued from page 1 Based on interview and record review, the facility failed to ensure an environment free from accident hazards and failed to provide adequate supervision to prevent avoidable accidents for 1 of 3 sampled residents (Resident #1). For Resident #1, who was at high risk for falls and required supervision while walking, staff failed to implement person-centered care plan interventions after multiple falls, ensure the resident was care planned for adequate supervision, and ensure staff assigned to care for residents in those rooms had the ability to provide the required supervision. On 6/30/26, Resident #1 experienced an unwitnessed fall and was found on the floor unresponsive and passed away on 7/01/26 from injuries sustained from the fall. These were systemic failures in supervision, care planning, and addressing repeated falls. Findings include: Per record review, Resident #1 was admitted to the facility on 01/24/2025 with diagnoses of Cerebral Infarction (commonly known as an ischemic stroke), Diplopia (a medical term for double vision, a condition where a person sees two overlapping or separated images of a single object), chronic kidney disease, subarachnoid hemorrhage (a bleeding into the subarachnoid space), and sequelae cerebral hemorrhage (refers to the lingering physical, cognitive, or psychological deficits that remain after a person has experienced bleeding inside the brain). Per record review Resident #1 had 10 falls since 2/27/26. 9 were unwitnessed. Resident #1's care plan created on 1/24/25 stated they are at risk for falls related to confusion, deconditioning, gait/balance problems, incontinence, vision/hearing problems and disease process secondary to diabetes, dementia, cerebral vascular accident, hypertension (high blood pressure) and seizures. S/he focuses on toileting/using the bathroom when restless and overestimates his/her abilities. The goal of the fall care plan that was in place in February 2026 was Resident #1 will not sustain serious injury through the review date. The Interventions in place prior to Resident #1 falling on 02/27/26 were: Anticipate and meet Resident #1's needs. Be sure Resident #1's call light is within reach and encourage the resident to use it for assistance as needed. The residents needs prompt response to all requests for assistance. Don't leave alone in the bathroom with the door closed.	F0689	How will the corrective actions be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place? For the next four weeks, the DNS and/or designee will conduct weekly audits of all falls and their corresponding fall risk evaluation scores, updated fall prevention interventions, and IDT review/root cause analysis of those with repeat falls. Weekly observational audits will be conducted on residents who experienced a fall within that week. After four weeks, random audits will be conducted monthly for three months and then randomly thereafter. Audit results will be reported to the facility Safety-Quality Committee. The dates corrective action will be completed. July 31, 2026 **Tag F0689 POC accepted on 8/5/26 by J. Wilder/S. Stem**	

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F0689 SS = SQC-J	Continued from page 2 Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Grips Strips left side of Bed and front of bathroom door. Monitor for s/s illness, change in mental status, and/or dizziness. Toilet [Resident #1] before and after each meal and at hours of sleep (HS). [Resident #1] needs to be reminded to use call bell help for help prior to getting out of their chair/bed--offer reminders and encouragement to ask for assistance; Will continue to remind [Resident #1] the importance of calling for help during transfers to improve safety. Resident #1 was care planned for monitoring and falls in their side-effects of pain medication focused care plan: Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician. Resident #1 had a care plan for activities of daily living (ADLs) that identified needs for supervision during toileting, ambulation and transfers. The focus of the care plan was "ADL selfcare performance deficit related to impaired balance, deconditioning and disease process secondary to diabetes, HTN, CVA, CKD, anemia, visuospatial deficit, dementia, and seizures." The interventions for this care plan were: TRANSFER: Resident #1 requires supervision for in-room transfers for transfers using a four wheeled rolling walker. AMBULATION: Ambulatory to tolerance in Nursing hallways using four wheeled rolling walker with 1 person close supervision. AMBULATION: tolerates equal to or greater than 500 feet using four wheeled rolling walker. Ambulate as tolerated/ or to physical therapy's desire. Encourage ambulation to-dine for all meals. [Resident #1] demonstrates decreased safety awareness, impulsive at times, and tends to bump into things (obstacles) due to decreased vision. TOILET USE: [Resident #1] requires supervision	F0689		

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F0689 SS = SQC-J	Continued from page 3 assist with toileting. Don't leave alone in bathroom. May wear medium pullups for urinary incontinence. May need reminders to void. Encourage the resident to use bell to call for assistance. There are a group of three private resident rooms where Resident #1's room was located. These rooms are the furthest distance from the nurses' stations on nearby Stark/Allen Unit and Moses/Frost Unit and are not able to be visualized from either. There are no other nurses' stations on this side of the facility. Staff working on Stark/Allen must walk off the Stark hallway, around the corner, through a common area to visualize the rooms. Staff on Moses Hallway must walk through a small activities room and around the corner to visualize these rooms. The call bell system for these rooms alerts the Moses/Frost nurses station, however the care for residents in those three rooms is assigned to Stark/Allen Unit. Per interview with Assistant Director of Nursing (ADON) on 7/6/26 at approximately 1:30 PM confirmed that the residents who live on the hall where Resident #1's room was, are assigned Nurses and Licensed Nurse's Aides (LNA) from the Stark/Allen Unit. That unit is located on the adjacent side of the building from the Moses/Frost units. The call bell systems for the three rooms on the separate short hall do not ring on the unit of which they are assigned, but at the Moses/Frost unit. Per record review, Resident #1 sustained an unwitnessed fall in their room on 2/27/26 at 3:40 PM. Resident #1's care plan was updated on 2/27/26 with the intervention of: Encourage and assist Resident # 1 to go to a quiet area as needed. Is triggered by loud activities. This new intervention does not address safety within their room. On 3/19/26 at 6:45 PM Resident #1 fell in the bathroom located in their room. Resident #1's care plan was updated on 3/19/26 with: Keep water valve in bathroom for the bed cleaning device closed when not in use. However, the care plan for toileting indicates the resident should always be supervised while in the bathroom. Per record review on 3/29/26 at 6:30 AM, Resident #1 had an unwitnessed fall in their room where they fractured and dislocated their right, third finger. Resident #1 was sent to the emergency department for treatment and returned to the facility. The care plan was updated on 3/29/26 with: Encourage	F0689		

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F0689 SS = SQC-J	Continued from page 4 Resident #1 to allow privacy curtains to be closed instead of his/her room door. There was a second intervention added after this fall: Perform safety checks on Resident #1 frequently through the night as they do not remember to use their call bell for assistance. These interventions do not address the falls occurring in the morning, afternoon and evening, or address why the resident was continuing to attempt to transfer/ambulate without the care planned supervision previously described. On 4/8/26 at 1:30 PM Resident #1 had an unwitnessed fall in their room. They sustained a head strike resulting in a scalp laceration. They were not sent to the hospital after this fall. The care plan was updated with: Keep walker close to Resident #1 so it will be available at all times. On 4/25/26 at 3:30 PM, Resident #1 had an unwitnessed fall in their room without injury. The resident's care plan was a revision of a previous intervention: Encourage resident to keep room door open. Date Initiated: 10/25/2025, Revision on: 04/27/2026. There was not a new intervention put into place after this fall, and after the fall 3/29/26 the intervention of allow privacy curtains to be closed instead of resident's room door was implemented. Per record review on 4/30/26 at 2:50 PM Resident #1 had an unwitnessed fall in their room without injury. The care plan was updated on 4/30/26 with the intervention of: Daughter will bring in smaller slippers as [Resident #1] needs to be encouraged to wear slip socks until new slippers arrive. However, Resident #1 was previously care planned for footwear initiated on 1/27/26: Ensure that [Resident #1] is wearing appropriate footwear (Shoes or nonskid socks) when ambulating or mobilizing in w/c. On 5/4/26 Resident #1 was sent out to the hospital for changes in mental status where they were admitted until 5/7/26, then returned to long-term care facility. Resident #1's care plan intervention for frequent safety checks at night which also informs staff that they do not remember to use their call bell, was cancelled. The intervention cancelled was: "Perform safety checks on [Resident #1] frequently through the night as s/he does not remember to use their call bell for assistance. Date Initiated: 03/29/2026, Cancelled Date: 05/04/2026." Interview with the Assistant Director of Nursing	F0689		

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F0689 SS = SQC-J	Continued from page 5 (ADON) on 7/7/26 at approximately 12:55 PM confirmed the intervention should not have been cancelled and Resident #1 should have been care planned for the increased supervision, and safety checks when they returned. Per record review on 5/24/26 at 10:45 AM, Resident #1 sustained another unwitnessed fall in their room. Resident #1 developed facial/eye bruising after this fall with no other noted injuries. The care plan was not updated after this fall. On 6/22/26 at 7:15 AM Resident #1 had a witnessed fall in their room where they sustained bruising to their elbow, a right arm laceration, and a reopening of a scab on the left arm. Resident #1's care plan was not updated after this fall, and the facility's post fall packet was not completed. On 6/30/26 at 9:30 AM Resident #1 had an unwitnessed fall in their room. The care plan was not updated after this fall. Interview with the ADON at approximately 12:55 PM on 7/7/26 confirmed the care plan had not been updated regarding falls since the fall on 5/24/26, and the fall packet for 6/22/26 was not completed. On 6/30/26 at 2:45 PM Resident #1 fell a second time that day and was found on the floor of their room face down, soiled in stool and urine. Resident #1 was then sent to the hospital for evaluation of injuries. Per record review of Southwestern Vermont Medical Center Emergency Department note written on 6/30/26, Resident #1 was found face down in their room. It is unclear how long they were on the ground. Per Emergency Medical Services who responded, resident was found "laying in a pool of blood". Resident #1 was assessed in the emergency department where it was identified they sustained a subdural hematoma (a subdural hematoma is a life-threatening collection of blood that pools between the brain's surface and the dura mater (its tough outer lining)), cerebral hemorrhage (a cerebral hemorrhage (or brain bleed) is a life-threatening medical emergency where a blood vessel bursts or leaks inside the skull), and multiple sinus fractures. Resident #1 was placed on comfort measures and passed away at the hospital on 7/1/26. Per interview on 7/7/26 at 1:25 PM with Licensed Practical Nurse (LPN) assigned to the Allen/Stark Halls, they stated that they don't know where the call bells for the group of three rooms where	F0689		

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F0689 SS = SQC-J	Continued from page 6 Resident #1 resided alert staff. Confirmed staff on the unit wouldn't know if their call bells were ringing or if they needed assistance unless they walked down to that separate hallway to see the rooms. Per interview on 7/7/26 at 1:44 PM with Licensed Nurses Assistant #1 (LNA) was assigned to the Stark hallway and confirmed their assignment included the rooms on the separate hallway where Resident #1's room was located. LNA #1 stated that it is impossible to supervise a resident with a significant fall risk in those three rooms specifically. LNA #1 confirmed that the call bell system for the rooms on that alert the Frost/Moses nurses' station and that staff from Frost/Moses will call via telephone to the nurses' station at Stark/Allen to notify them a call bell is on. LNA #1 stated they are not always able to get to the phone because they are often in rooms or walking the hall to provide care and assist residents and cannot hear it or get to it. Per interview with LNA #2 on 7/7/26 at 2:14 PM assigned to Moses Hall stated that when call bells for the three rooms on the separate smaller hallway are lit s/he will go answer them if they can. LNA #2 confirmed they sometimes work on Stark/Allen and it is very difficult for Stark Hall staff to have those rooms on their assignment because the call bells for those rooms do not alert the Stark nurse's station and the rooms are hard to supervise because it is far away from the units. Sometimes staff from Moses Hall round on those rooms but it all depends on the staff member, not everyone does or has the time. Per interview with the ADON on 7/7/26 at approximately 2:41 PM Resident #1 ambulated using a four wheeled rolling walker with supervision. ADON felt the facility implemented everything they could to reduce falls, except for moving Resident # 1's room closer to the nurse's station for more supervision or initiating 24/7 one to one supervision. Per review of the facility's policy titled: Accidents and Incidents, which does not contain a revision date, states: "The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent reoccurrences and improve the management of resident care". Per review of the facility's policy titled: "Fall Prevention and Protocol-CLR last reviewed on 6/10/2025...IV. Policy Statement section 7. Care planning: a. Document appropriate interventions on the resident/patients care plan related to fall	F0689		

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F0689 SS = SQC-J	Continued from page 7 prevention. Examine previous fall patterns and if known document this on the care plan well. b. During regularly scheduled reviews of the care plan, ensure that all interventions related to prevention of falls remain appropriate."	F0689		