VERMONT

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

July 25, 2025

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 **June 30, 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: 475029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/30/2025

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 conducted an unannounced, onsite investigation of complaint intake # 24167 on 6/30/2025 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. A regulatory violation was identified during the investigation.	F0000		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that a resident did not develop an avoidable pressure ulcer for 1 of 3 residents in the sample (Resident #1). Findings include: Per record review Resident #1 was re-admitted to the facility on 5/14/2025 after a short discharge to home. A Clinical Admission Note reflects that s/he was admitted with a diabetic foot ulcer on her/his left heel. There is no mention of any wound being present on the right heel. Review of the Resident's care plan reveals a Focus dated 5/15/2025 of "actual impairment to skin integrity."	F0686	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The care plan for Resident # 1 was reviewed and updated with appropriate wound prevention interventions. 2. 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 will be conducted to identify all residents who are at high risk for pressure injuries. Care plans will be reviewed and updated as indicated. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The following policies will be reviewed and updated as indicated: "Body Audit"; "Pressure Ulcer Risk Assessment"; "Pressure Ulcer Management"; "Skin Integrity Maintenance Protocol"; and "Skin Inspection and Monitoring Procedure". Education will be provided to all nursing staff regarding wound prevention and identification/documentation procedures. 4. 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 random audits/observations of skin check completion. After four weeks, random audits/observations will be conducted monthly for three months and then randomly thereafter. Results of the audits will be reported to the facility Safety-Quality Committee. 5.The dates corrective action will be completed. Corrective Action will be completed by July 30, 2025. **Tag F0686 POC accepted on 7/25/25 by S. Freeman/S. Stem**	

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
Damon A. Wood RN	DNS	7/25/2025

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 06/30/2025

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F0686 SS = D	Continued from page 1 A Nurse Progress Note dated 6/2/2025 states "This writer noted that resident had blood on right sock. Noted to have area to right heel. Supervisor made aware, and came to assess. Family made aware." Another Nurse Progress Note dated 6/2/2025 states "resident has a open area on his right heel, supervisor [name omitted] assessed area, 5x5 cm broken blister noted red inner tissue surrounded by white soft tissue with dark pink edges, Slight odor." Resident #1 was transferred to the hospital later in the day on 6/2/2025 and returned to the facility on 6/5/2025. A Nurse Progress Note dated 6/5/2025 reflects that Resident #1 returned to the facility with a "Right heel. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Stage 2 Pressure ulcer /injury - partial thickness skin loss with exposed dermis. Wound was present on admission. Length (cm): 7 Width (cm): 5 Depth (cm): 0.1." The right heel wound was present on readmission however, it had been identified in the facility on 6/2/2025, the day that the Resident transferred to the hospital. A Care Plan Focus of actual impairment to skin integrity lists an intervention dated 5/15/2025 lists interventions of "Air mattress to bed (applied on admission--uses chronically due to wounds and high risk for wounds). On 6/7/2025 "Bilateral heel booties on at all times--remove for skin care and transfers then reapply," was added to Resident #1's care plan. On 6/20/205 the care plan was revised to reflect "Use cushion with sides to promote elevation of feet." Another Care Plan Focus for at risk for pain has interventions of "Elevate Bil [bilateral] heels when in bed as desired." These protective interventions were not implemented until 6/7/2025, after the right heel pressure ulcer was identified. Per interview with the Director of Nursing on 6/30/2025 at 5:30 PM, she confirmed that the right heel wound had developed in the facility and that there were no documented interventions related to protecting the right heel from developing pressure ulcers prior to 6/2/2025.	F0686		