VERMONT

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

January 27, 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 **December 16, 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 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center for Living & Rehabilitation	**160 Hospital Drive , Bennington, Vermont, 05201**

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F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of three complaints and one facility reported incident, including reports #2623266, #2620506, #2612275, and #2608502 from 12/15/25 through 12/16/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F0000	F 600 Free from Abuse and Neglect 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident # 1 and Resident #2 routinely reside on different hallways. Both are alert and oriented with BIMS of 15/15 and can actively participate in the development of a safety plan. A safety plan for use of common areas will be developed and implemented. Review and education of the plan will be provided to both residents. 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 any other residents who would require similar plans. 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: "Abuse, Neglect, and Exploitation", "Routine Resident Checks"; " Safety Checks", "Resident Safety Plan". Education will be provided to all staff regarding the following policies "Abuse, Neglect, and Exploitation", "Routine Resident Checks"; " Safety Checks", "Resident Safety Plan" and education will be provided on intervention strategies to prevent negative resident interactions. Weekly reviews of the safety plan will be scheduled for the next 3 months with each resident.	
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to ensure residents' right to be free from physical and verbal abuse from another resident for 2 of 3 sampled residents (Resident #1 and Resident #2). The facility did not implement effective interventions to prevent recurrence after a prior altercation on 8/7/25, nor did it update care plans to address ongoing risk. On 9/17/25, Resident #1 sustained blunt trauma to the nose with bleeding after being struck by Resident #2 during a physical altercation, and Resident #1 expressed feeling unsafe and distressed in his/her home. This deficient practice resulted in actual	F0600		

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F0600 SS = G	Continued from page 1 physical harm and psychosocial harm. Findings include: Per record review, the Minimum Data Set (MDS, an assessment tool) dated 10/15/25 reveals that Resident #1 has a BIMS score (Brief Indicator for Mental Status, a test to check if thought processes are intact) of 15 out of 15, indicating cognition is intact. Resident #1 has diagnoses that include anxiety disorder and major depressive disorder. Resident #1 has a care plan focus dated 12/20/23 and revised on 11/14/25 that states, "[Resident #1] is at risk for harm r/t [related to] behaviors that impact others. Will repeat statements at times and can become verbally and physically aggressive towards others at times. [Resident #1] can misinterpret situations and/or conversations and can demonstrate accusatory behaviors toward staff when [he/she] doesn't understand what is being communicated." Per record review, the MDS dated 10/28/25 reveals that Resident #2 has a BIMS score of 15 out of 15, indicating cognition is intact. Resident #2 has diagnoses that include anxiety disorder and bipolar disorder. Resident #2 has a care plan focus dated 3/5/25 and revised 11/14/25 that states, "[Resident #2] has potential to be verbally aggressive and can make accusations towards staff r/t Ineffective coping skills," with an intervention dated 3/5/25 and revised 8/22/25 for, "When [Resident #2] becomes agitated: If safe and feasible, gently guide [him/her] away from the source of distress or the current environment to a calmer, less stimulating are (e.g., quiet room, outside if appropriate); Engage in a conversation. If not safe to engage, ensure safety by calmly walking away and allowing [him/her] time to de-escalate before re-approaching and attempting to re-engage." Per record review, Resident #1 and Resident #2 had a physical incident between each other on 8/7/25. A facility reported incident (FRI) was reported to the state on 8/8/25 that describes an observed event where Resident #1 pushed his/her wheelchair into Resident #2 and kicked Resident #2. Resident #2 complained of discomfort to their leg. Per a record review, a facility reported incident (FRI) was submitted to the State Agency on 9/18/25, with an allegation of physical abuse related to a resident-to-resident altercation that occurred on 9/17/25 between Resident #1 and Resident #2. The report describes on 9/17/2025 "The ADON (Assistant Director of Nursing) and NP (Nurse Practitioner) were at the opposite end of the hallway at the nursing station when they saw [Resident #1] approach [Resident #2]. Per their report, they heard words exchanged but could not	F0600	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 4 weeks, the DNS and/or designee will conduct weekly random interviews to evaluate compliance with the safety plan. After four weeks, random audits/observations will be conducted monthly for three months and then randomly thereafter. Results of the interviews will be reported to the facility Safety-Quality Committee. 5. The dates corrective action will be completed. January 30, 2026 **Tag F 600 POC accepted on 1/27/26 by S. Freeman/S. Stem**	

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F0600 SS = G	Continued from page 2 distinguish exactly what was said. The tone appeared negative, so both the NP and the ADON immediately left the nursing station to intervene but before they reached the two residents, they saw [Resident #1] run [his/her] wheelchair more than once into [Resident #2's] wheelchair. [Resident #2] responded by striking [Resident #1] in the face with a closed fist (left hand). Upon assessment, [Resident #1's] nose was noted to bleed and [Resident #2] complained of left-hand discomfort." Per a record review, a 5-day investigation summary, including resident statements and staff witness statements, was submitted to the State Agency on 9/18/25. The summary corroborates that a physical altercation and threats occurred between Resident #1 and #2 on 9/17/25. There was nothing in the facility's investigation that revealed that staff attempted to separate the two residents prior to the event occurring. Per record review, a nursing progress note written on 9/17/25 stated the following, "At approximately 1100 [Resident #2] was witnessed by this writer to be sitting in front of [his/her] room in his wheelchair ... when another resident [Resident #1] who lives in another area came wheeling down the hallway toward this resident. Words were exchanged between the two residents, but this writer could not hear what was said. This writer began to run up the hallway to intervene just as the [Resident #1] started slamming [his /her] wheelchair into the side of this residents wheelchair. [He/she] slammed into this residents wheelchair 2 or 3 times before this resident [Resident #2] pulled back [his/her] fist and punched the other resident [Resident #1] in the face resulting in a bloody nose. This writer along with another nurse and NP had arrived at the incident and separated the residents at this time. [Resident #1] stated to [Resident #2] 'I am going to get a gun and shoot you, you fat piece of lard' over and over several times. The other resident was taken back to [his/her] room... [Resident #2] was assessed by RN and stated that [his/her] left hand/knuckles hurt." Per record review, a 9/17/25 NP progress note states, "I saw [Resident #1] down the hall interacting with [Resident #2]; [he/she] was propelling [his/her] wheelchair around [him/her] and they were conversing. Then they raised their voices and began lashing out at each other physically. When I reached them, [Resident #1] had blood dripping down [his/her] face seemingly from [his/her] nose, and the other resident was gripping [Resident #1's] left forearm. They were	F0600		

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F0600 SS = G	Continued from page 3 separated and I took [Resident #1] back to [his/her] room. [He/she] denied pain but was clearly angry and distressed." Per record review, Resident #1 was sent to the emergency department following the event and discharged back to the facility with blunt trauma to the nose with a bleed. Per interview with Resident #1 on 12/15/25 at 12:55 PM, Resident #1 stated that someone hit him/her on his/her nose. Resident #1 did not know why he/her got hit on the nose and stated that s/he does not feel safe at the facility. Per an interview with Resident #2 on 12/15/25 at 3:50 PM, Resident #2 stated that Resident #1 had run into him/her with his/her wheelchair and that he/her had responded by punching Resident #1 in the nose. With regard to Resident #1, Resident #2 stated, "[He/she] has problems. I don't bother [him/her] but [he/she] is relentless." Resident #2 stated that he/her does not believe that Resident #1 seeks him/her out, but that there is a problem when they do see each other. Per interview with the DON (Director of Nursing) at 4:18 PM on 12/15/25, she confirmed there is nothing specific in Resident #1 or Resident #2's care plans or Kardex with regard to keeping them apart or protecting them from each other, following either of the two altercations. See F657 for more information.	F0600		
F0657 SS = G	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F0657	F 657 Care Plan Timing and Revision 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The care plans for Resident #1 and Resident #2 were reviewed and updated as indicated. 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 of all residents will be conducted to identify those with a history of resident altercations. The care plans of those identified will be reviewed and updated as indicated.	

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F0657 SS = G	Continued from page 4 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to review and revise the comprehensive care plans for 2 of 3 sampled residents (Residents #1 and #2) after significant changes in condition related to two resident-to-resident altercations. Despite an initial incident on 8/7/25 and a subsequent altercation on 9/17/25 resulting in Resident #1 sustaining blunt trauma to the nose and expressing fear and distress, the facility did not update either resident's care plan or Kardex to include interventions to prevent recurrence, such as separation or monitoring. Staff interviews confirmed reliance on informal redirection rather than documented interventions. This failure resulted in actual physical harm and psychosocial harm to Resident #1. Findings include: Per record review, the Minimum Data Set (MDS, an assessment tool) dated 10/15/25 reveals that Resident #1 has a BIMS score (Brief Indicator for Mental Status, a test to check if thought processes are intact) of 15 out of 15, indicating cognition is intact. Resident #1 has diagnoses that include anxiety disorder and major depressive disorder. Resident #1 has a care plan focus created on 12/20/23 and revised on 11/14/25 that states, "[Resident #1] is at risk for harm r/t [related to] behaviors that impact others. Will repeat statements at times and can become verbally and physically aggressive towards others at times. [Resident #1] can misinterpret situations and/or conversations and can demonstrate accusatory behaviors toward staff when [he/she] doesn't understand what is being communicated." Per record review, the MDS dated 10/28/25 reveals that Resident #2 has a BIMS score of 15 out of 15, indicating cognition is intact. Resident #2 has	F0657	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: "Plan of Care", " Interdisciplinary (IDT) Plan of Care (POC) Document", and "Care Plan Meeting" will be reviewed and updated as indicated. The checklist for altercations will be reviewed and updated as indicated. Education will be provided to nursing supervisors and leaders regarding use and completion of the checklist. Education will be provided to all nurses and social workers regarding the process for review and updating of care plans. 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 randoms audits of care plan updates. After four weeks, random audits will be conducted monthly for three months and then randomly thereafter. Results of the interviews will be reported to the facility Safety-Quality Committee. 5. The dates corrective action will be completed. January 30, 2026 **Tag F 657 POC accepted on 1/27/26 by S. Freeman/S. Stem**	

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F0657 SS = G	Continued from page 5 diagnoses that include anxiety disorder and bipolar disorder. Resident #2 has a care plan focus created on 3/5/25 and revised on 11/14/25 that states, "[Resident #2] has potential to be verbally aggressive and can make accusations towards staff r/t Ineffective coping skills," with an intervention dated created on 3/5/25 and revised on 8/22/25 for, "When [Resident #2] becomes agitated: If safe and feasible, gently guide [him/her] away from the source of distress or the current environment to a calmer, less stimulating are (e.g., quiet room, outside if appropriate); Engage in a conversation. If not safe to engage, ensure safety by calmly walking away and allowing [him/her] time to de-escalate before re-approaching and attempting to re-engage." Per record review, Resident #1 and Resident #2 had a physical incident between each other on 8/7/25. A facility reported incident (FRI) was reported to the state on 8/8/25 that describes an observed event where Resident #1 pushed his/her wheelchair into Resident #2 and kicked Resident #2. Resident #2 complained of discomfort to their leg. Per record review, a facility reported incident (FRI) was submitted to the State Agency on 9/18/25, with an allegation of physical abuse related to a resident-to-resident altercation that occurred on 9/17/25 between Resident #1 and Resident #2. Resident #1 ran his/her wheelchair into Resident #2, multiple times. Resident #2 responded by punching Resident #1 in the nose while stating, "I am going to get a gun and shoot you, you fat piece of lard". As a result of the 9/18/25 incident, Resident #1 was taking to the emergency department for blunt trauma to the nose with a bleed. A 9/17/25 NP progress note "was clearly angry and distressed" by the altercation. On 12/15/25 at 12:55 PM, Resident #1 stated that s/he does not feel safe at the facility. See F600 for more information. Per interview with LNA #1 (Licensed Nursing Assistant) at 4:08 PM on 12/15/25, the Kardex (a quick reference tool for referencing patient needs) tells staff what to look for regarding specific residents. LNA #1 was not aware of Resident #1 having trouble with any specific residents. Per an interview with the Unit Manager at 4:10 PM on 12/15/25, the facility's strategy to keep Resident #1 and Resident #2 separated is "to try to keep them apart." The Unit Manager stated that information should be care planned and in the Kardex. Per record review,	F0657		

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F0657 SS = G	Continued from page 6 there was nothing to indicate keeping Resident #1 and Resident #2 apart in either resident's Kardex or in either resident's care plan. Per interview with the DON (Director of Nursing) at 4:18 PM on 12/15/25, the facility attempts to keep Resident #1 and Resident #2 separated by "kind of just redirecting them." The DON confirmed there is nothing specific in Resident #1 or Resident #2's care plans or Kardex with regard to keeping them apart or protecting them from each other, following either of the two altercations.	F0657		