VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
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AGENCY OF HUMAN SERVICES

February 9, 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 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 12/30/2025

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 on 12/30/25 of two complaints (#2659808, and #2646277) to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory violations were identified:	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F0550	F550 Resident Rights/Exercise of Rights 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident # 1's will be interviewed and her care plan will be updated with her preference for preferred name and/or pronoun. 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? Interviews will be conducted with all interviews able residents to evaluate dignified care and preferences for name choice/communication. 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 were reviewed and updated as indicated: "Abuse, Neglect, and Exploitation" ,"Plan of Care", and "Resident Rights". Education was provided to all staff regarding resident rights, dignity and respectful communication and the use of the care plan to indicate preferences for name and/or pronoun.	

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
Meghan T Mann	Administrator	1/30/2026

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F0550 SS = D	Continued from page 1 interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, the facility failed to ensure that 1 of 4 residents in the sample were treated with dignity and respect (Resident #1). Findings include: Per observation on 12/30/2025 at approximately 4:15 PM, Licensed Practical Nurse #1 (LPN) was observed answering Resident #1's call bell. Resident #1 requested pain medication. LPN #1 addressed the resident as "Boo" three different times within their interaction. Per interview with Resident #1 on 12/30/2025 at 4:34 PM, Resident #1 stated "my name is (proper name omitted), it's not Boo and I don't know why (LPN #1) would call me that." Per interview with LPN #1 on 12/30/2025 at 4:52 PM, they stated Resident #1"s nickname is not "Boo" it's just a figure of speech and "it's what I call everybody." Per interview on 12/30/2025 at approximately 7:45 PM with the Administrator (ADM), she stated that it is not appropriate to address residents with terms of endearment and that staff should address the residents by their preferred name or pronoun.	F0550	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 interviews to evaluate dignity in communication with residents/patients. 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 550 POC accepted on 2/6/26 by J. Kendall/S. Stem**	
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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:	F0697		

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F0697 SS = D	Continued from page 2 Based upon observations, interviews, and record review, the facility failed to ensure adequate pain control was provided for 1 of 4 sampled residents (Resident #1). Findings include: Per record review, Resident #1 was admitted to the facility with diagnoses that include chronic pain syndrome and osteoarthritis (a diagnosis affecting joint cartilage causing pain swelling and stiffness of the affected joints). Resident #1 has a BIMS [Brief Interview for Mental Status] score of 14, dated 10/7/25, indicating cognitive function is intact. Per observation on 12/30/2025 at 3:10 PM, Resident #1 vocalized with increased volume "help." At 3:13 PM, LNA (Licensed Nursing Assistant) #1 entered the room. Resident #1 stated that they wanted to get into bed and that their back hurt. LNA #1 told Resident #1 they needed to stay up in their chair for dinner. Per interview with Resident #1 at 3:46 PM on 12/30/2025, s/he stated that s/he had asked a staff member to lie down in bed because of their back pain and that s/he was told s/he needed to stay up for dinner. Per observation at 3:53 PM, three staff members wheeled the Hoyer lift [equipment to lift and transfer a person] entered Resident #1's room. S/he was transferred to bed at that time. Resident #1 stated pain in their lower back was a 9 out of 10 and that they receive Tylenol for pain management but "they won't bring it." Resident #1 pushed the call bell at 4:10 PM to notify the nurse that they would like pain medicine. Per observation on 12/30/2025 at 4:15 PM, LPN #1 (Licensed Practical Nurse) entered Resident #1's room to address the call bell. LPN # 1 told Resident #1 they do not have PRN (as needed) pain medication and that they receive scheduled Tylenol that is not due until 8:00 PM that evening. LPN #1 asked Resident #1 to rate their pain on a scale of 1-10 and describe the location. Resident #1 stated their pain was a 9 out of 10 in their lower back and that the scheduled Tylenol does not seem to be managing the pain. LPN #1 stated they'd notify the provider about Resident #1's concerns of Tylenol not appropriately managing their pain, and that the provider would see Resident #1 on rounds the following day to address this. LPN #1 also stated to Resident #1 they have a topical pain relief cream that will be applied at bedtime. The LPN did not offer any non-pharmacological options (back rub, meditation, music, aromatherapy, etc.) to help with Resident #1's current pain.	F0697	F 697 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident # 1's pain management regime was reviewed and updated as indicated. NP reviewed medication regime and new orders were received and administered on 12/30/2025. 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 resident pain management regimes will be reviewed. Any concerns will be addressed 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 were reviewed and updated as indicated: "Pain Management"; and " Medication Administration". Education will be provided to all nursing staff regarding pain assessment and management. 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 of pain management. 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 697 POC accepted on 2/6/26 by J. Kendall/S. Stem**	

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F0697 SS = D	Continued from page 3 Per record review, a Progress note from LPN #1 entered at 4:15 PM on 12/30/2025 stated: "Summoned to res [resident] room, res c/o [complaint of] pain to lower back and lower leg. MAR [Medication Administration Record] reviewed. No PRN pain medications ordered. educated res that [s/he] have Tylenol scheduled. Res stated Tylenol is ineffective. Message sent over to NP / MD." Per review of Resident #1's orders, an order from the provider dated 7/30/2024 with an indefinite end date states "May use facility standing orders." Per review of a document titled "Center for Living and Rehabilitation Standing Orders" revised/reviewed on 11/21/2024 a standing order for a topical pain relief treatment read "Muscle rub: apply topically to affected area every two hours as needed, notify provider if ineffective." Resident #1 has an order that states "Acetaminophen Oral Tablet Extended Release 650 milligrams every 8 hours for back pain Notes: FOR PRN PAIN USE - Ensure that Non-Pharmacological Interventions are in Additional Directions and Supplemental documentation as follows: Nonpharmacological Interventions 1. Reposition 2. Back rub 3. Music 4. Diversional activity." At the time of Resident #1's pain assessment, LPN #1 did not offer nonpharmacological interventions, or standing order for topical pain relief ointment." Per interview at 7:40 PM with the Director of Nursing (DON) and Administrator (ADM), they confirmed that an assessment revealing a pain level of 9 on a scale of 1-10 should be addressed timely and before the provider rounds the following day. They also confirmed nonpharmacological approaches should be offered/implemented for pain management.	F0697	F919 Resident Call System 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident # 1's call light was assessed for appropriate length and functional clip for proper placement for use. 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? All residents are considered to be at risk. 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 were reviewed and updated as indicated: "Abuse, Neglect, and Exploitation" , "Plan of Care", and " Resident Rights". Education was provided to all staff regarding resident rights and use of the call light system. Call light audit tool was reviewed and updated.	
F0919 SS = D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities.	F0919		

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F0919 SS = D	Continued from page 4 This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure that of 1 of 4 sampled residents had access to the call bell in their room (Resident #1). Findings include: Per record review, Resident #1 was admitted with diagnoses that include chronic pain syndrome, morbid obesity, lymphedema, (Lymphedema refers to tissue swelling caused by fluid that's usually drained through the body's lymphatic system. It most commonly affects the arms or legs, and severe cases of lymphedema can affect the ability to move the affected limb), and osteoarthritis (a diagnosis affecting joint cartilage causing pain swelling and stiffness of the affected joints). Review of Resident #1's Minimum Data Set Assessment (MDS) with a reference date of 10/07/2025 revealed Resident #1 has a BIMS (Brief Interview for Mental Status) score of 14 indicating Resident #1 is cognitively intact. Per observation on 12/30/2025 at 3:10 PM Resident #1 was sitting in a wheelchair in their room, facing the window and vocalized with increased volume "help." The call bell was observed pinned on the top sheet of the resident's bed out of their reach. Per interview with Resident #1 at 3:46 PM on 12/30/2025, they stated s/he was brought to their room after bingo and requested to go to bed, staff said they would be right back. Resident stated that s/he could not reach the call bell for assistance and had to use their cell phone to call a friend and ask their friend to call the facility's nurse's station. Resident #1 stated that is the only reason someone came to their room to give them their call bell and turn their chair around. Resident #1 was observed during interview facing the door to the hallway, call bell hanging over the foot board where they could reach it while sitting in the wheelchair at the foot of the bed. Per interview with Licensed Practical Nurse (LPN) #1 on 12/30/2025 at approximately 4:29PM, they stated that Resident #1 is "impatient" so s/he provided re-education to the resident about their requirement for two-person assistance with transfers. LPN #1 confirmed that resident's friend/family member called the facility to have staff go into the resident's room and assist the resident.	F0919	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 of call light use and placement. 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 919 POC accepted on 2/6/26 by J. Kendall/S. Stem** 2/6/26 POC reviewed and approved. Jane Kendall	