VERMONT

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

May 21, 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 recertification survey conducted on **April 8, 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 04/08/2026

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
E0000	Initial Comments An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection on 4/6/26 to 4/8/26 including Emergency Preparedness Requirements for 42 CFR Part 483 requirements for Long Term Care Facilities. The result of the Emergency Preparedness Survey identified no regulatory violations.	E0000	F 689 Free of Accident Hazards/Supervision/Devices 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A smoking safety evaluation was conducted for Resident #15. Based on the assessment, he was provided with a lockbox for his lighter and his care plan was 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?	
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and investigation of 2 complaints, including reports # 2976052 and # 2976228, from 4/6/26 through 4/8/26 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. No deficiencies were cited as a result of the complaint investigations. A deficiency was cited as a result of the recertification survey.	F0000	An audit was conducted to identify any other residents who were smoking. None were noted. 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 policy was reviewed: "Tobacco Free Workplace Policy". Based on the review, a new policy regarding "Smoke Free Campus" will be developed. Education will be provided to all staff regarding the new policy.	
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 observation, interview, and record review, the facility failed to provide supervision related to smoking for 1 of 1 sampled residents (Resident #15). Additionally, the facility failed to monitor the storage of Resident #15's lighter and cigarettes. This is a repeat deficiency, with the violation being cited during the past two recertification surveys dated	F0689	Education will be provided to Resident #15 regarding the new policy. 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 resident and staff education and compliance with the updated smoke-free policy. 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. May 22, 2026 **Tag F0689 POC accepted on 5/21/26 by M. Jean/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
Mary T Moore	Administrator	May 1, 2026

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 04/08/2026

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F0689 SS = D	Continued from page 1 4/30/25 and 3/27/24. Findings include: Per record review, Resident # 15 is care planned for smoking, revised on 7/28/25. Resident #15's care plan goal is to not smoke without supervision. Care plan interventions include educating the resident on the facility's policy about smoking locations, times, and safety concerns. Per observation, at approximately 12:55PM on 4/7/26 a person is sitting in a wheelchair, outside the entrance to the facility smoking a cigarette. There are no observed staff members outside. Per interview with the Receptionist at 12:57 PM on 4/7/26, the resident outside was Resident #15, and s/he is permitted to sit outside without staff supervision. Per interview 4/7/26 at approximately 1:03 PM with the Assistant Director of Nursing (ADON), they stated that Resident #15 used to smoke and had recently quit. S/he explained Resident #15 signed the facility's admission agreement that states the facility is non-smoking and residents will not smoke while living there. Resident #15 has been seen in the past on several occasions by staff members outside smoking and returning to the facility smelling like smoke. The ADON confirmed the facility has been working with the resident to assist with smoking cessation utilizing lollipops and nicotine replacement. The ADON confirmed there are 7 residents that wander and 26 residents with a diagnosis of dementia on Resident #15's unit Per interview on 4/7/26 at 1:10 PM with the Administrator, Resident #15 used to smoke and had quit on 4/4/26. S/he confirmed that the facility was aware that Resident #1 was smoking on facility grounds prior to 4/4/26 with supervision of staff and Resident #15 has not had a smoking safety assessment. Additionally, Resident #15 manages/stores their cigarettes and lighters/ignition devices independently as they are their own person and alert and oriented. Per interview with Resident #15 at approximately 1:30 PM on 4/7/26 they are trying to quit smoking, but it is challenging. S/he expressed it is a trigger when staff provide care smelling like smoke. Resident #15 stated the facility allows them to go outside to smoke independently without staff supervision. S/he stated s/he keeps their cigarettes and lighter in their shirt pocket or nightstand drawer.	F0689		