STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bennington Health & Rehab	2 Blackberry Lane Bennington, VT 05201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to ensure that each resident receives adequate supervision to maintain safety and prevent elopement for 1 or 1 sampled residents (Resident #1). Findings Include:A progress note dated 4/30/26 stated that Resident #1 left the faciity on an unauthorized leave of absence. A document completed by the facility titled: Elopement Drill Documentation form stated Resident #1 was identified missing at 9:42 PM. Resident #1 was located by [NAME] Police Department at their partners apartment and returned to facility at 10:12PM.Per record review, Resident #1 has a Brief Interview for Mental Status (BIMS) score of 14. (BIMS is a standardized cognitive screening tool used primarily in long-term care and skilled nursing facilities to assess a resident's memory, thinking, and orientation skills. A score of 14 indicates intact cognitive function). Resident #1's care plan indicates that they can ambulate independently with a walker or wheelchair and are at risk for falls.Per interview with Resident #1 on 6/30/26 at 8:32 AM, s/he stated they left the facility in a hurry because they were concerned about their spouse when they learned their spouse was in hospital. Resident #1 confirmed they did not utilize the facility's protocol for a leave of absence because they did not have a ride and they were not thinking clearly. Resident #1 confirmed they walked with their walker to the apartment complex where their spouse lives approximately 0.7 miles from the facility. Resident #1 stated it took a very long time to get there. [NAME] Police Department arrived and brought Resident # 1 back to the facility. Per interview with Physical Therapist #1 on 6/30/26 1:45 PM, they stated that Resident #1 does have balance issues, poor safety awareness, and frequently becomes short of breath with ambulation.Per interview with the Communications Specialist at [NAME] Police Department on the morning of 6/30/26, they read from a police report of the elopement that a call came in at 9:30 PM on 4/30/26. It was reported that Resident #1 had eloped from the facility. The facility reported they had last seen Resident #1 30 minutes prior to the call. The resident had gone to the spouse's house. Between 10:02PM and 10:07 PM [NAME] Police found Resident #1 and returned them to the facility.Per interview with the Administrator on 6/30/26 at approximately 11:15 AM, the facility was unaware that Resident #1 had left facility grounds at the time of their departure. Resident #1 is their own person who on occasion uses the facility's leave of absence pass to go out with a friend or family. The Administrator confirmed they reviewed the camera footage from 4/30/26 and Resident #1 exited through the front door as a visitor was entering and went to the right of the building. The Administrator confirmed the footage did not show Resident #1 entering a vehicle. The Administrator confirmed Resident #1 should not have been able to exit the facility without staff knowing. The facility has a 24 hour 7 days a week receptionist at the front door and the front door locks at 8:00PM. Some family members have the code to enter the building. At approximately 12:35 PM she confirmed they may not have remembered the exact time the resident departed when reviewing the facility's camera footage.

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 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