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	12/10/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that residents who require dialysis receive services consistent with professional standards of practice and the comprehensive, person-centered care plan for one of one residents (Resident #5). Findings include: Per record review, Resident #5 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, anemia in chronic kidney disease, and dependence on renal dialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys cannot). The Resident has a central venous catheter (a soft plastic tube, tunneled under the skin and placed in a vein in the neck, chest, or groin, which enters a central vein that leads to the heart). Review of Resident #5's Care Plan reveals a Focus area for the Resident is at risk for worsening impaired renal function and is at risk for complications related to hemodialysis, which was initiated on 10/7/25. One of the interventions listed is to maintain smooth catheter clamps at the bedside (and on patient when out of bed) in case of breakage or excessive bleeding from catheter, which was also initiated on 10/7/25. During observations on 12/8/25 at 1:00 PM, no smooth clamps were located at the bedside in Resident #5's room.Per interview on 12/9/25 at 2:30 PM with the Unit Manager (UM), she stated that the Resident should have an Emergency Kit at the bedside, including the smooth clamps. The UM then asked one of the nurses to check the kit for the clamps. He returned and stated the kit was at the bedside but didn't include the clamps. During an observation on 12/9/25 at 3:16 PM with the Director of Nursing (DON) and the UM, the kit in Resident #5's room didn't include the needed smooth clamps. The DON confirmed again that the clamps need to be added and that the emergency kit should be with the Resident at all times, including when they are off-site for dialysis.ReferenceNational Kidney Foundation. 2023, January 1. Dialysis (https://www.kidney.org/kidney-topics/dialysis)MedlinePlus. 2024, October 28. Daily assessment of the vascular access site is necessary to avoid infection, blood clots, and other problems. (https://medlineplus.gov/ency/patientinstructions/000591.htm)The American College of Surgeons. 2017. What Is a Central Venous Access Device (CVAD)? (https://www.facs.org/media/2tcnbb4f/understanding_your_central_line.pdf)

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

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	12/10/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on interview and record review, the facility failed to provide or obtain laboratory services when ordered by a physician; and/or notify the physician when ordered labs were not completed for one resident [Resident #6] of 29 sampled residents.Findings include:Per review of Resident #6's medical record, a third eye health note [a telemedicine service which examines patients remotely via video and audio] dated 11/25/25 reveals the resident was seen for new-onset gross hematuria [where blood is visible in the urine]. [H/she] is noted to be on Eliquis [an anti-blood clotting medication] with no reports of hematuria in the past (although [h/she] was recently hospitalized for a Gastro-Intestinal Bleed two times in September and October).According to the Mayo Clinic, the healthy range for hemoglobin is: For men, 13.2 to 16.6, for women, 11.6 to 15.[Hemoglobin (abbreviated Hgb or Hb) is the protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues].The telemedicine note continues: Recent Hgb levels [for Resident #6]: 8.2 on 11/13/2510.9 on 10/9/25Diagnosis, Assessment/Plan: - Gross hematuria (Primary). This is an acute new problem. Condition is worsening. Will hold AM Eliquis [anti blood clotting medication] if recurrent hematuria overnight and check CBC in A.M. [A complete blood count (CBC) is a blood test that measures amounts and sizes of red blood cells, hemoglobin, and other blood components].Review of Physician Orders for Resident #6 on 11/25/26 include Hold A.M. Eliquis for recurrent hematuria overnight - Check CBC/BMP [BMP (basic metabolic panel) is a test that measures several important aspects of blood, like electrolytes and blood sugar]. - Notify a clinician of any change in condition.Further review of Resident #6's medical record revealed no documentation that the Physician Order for CBC dated 11/25/25 was completed as ordered, and/or results obtained and the physician notified. An interview was conducted with the Director of Nursing [DON] on 12/9/25 at 4:42 PM. The DON confirmed that the Physician Order for labs for Resident #6 were never completed and/or the physician notified.The DON reported an order for the CBC was entered and completed after the interview with the surveyor on 12/9/25. Review of Change of Condition notes for Resident #6 on 12/9/25 regarding the newly completed labs reveal lab critical value reported by [hospital] lab for 7.8 hemoglobin down from 8.2 from previous lab. Resident #6's Physician responded by ordering a test for blood in the stool and to repeat the CBC blood work in two days.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and policy reviews, the facility failed to store food in accordance with professional standards for food service safety. This deficiency has the potential to impact all residents in the facility. This is a repeat deficiency for this facility, with the violation cited during a previous partial survey dated 7/16/25. Findings include:1. Per the initial tour of the Kitchen on 12/8/25 at 10:49 AM, a rack containing dishware was revealed. The Dietary Manager stated the dishware was ready for use. There was half a tray of cups that had been flipped upside down and were observed to be wet on the sides, and the bottoms of each cup. The Dietary Manager confirmed the cups were ready for use but hadn't been dried correctly. The Dietary Manager stated the cups should've remained on a drying rack to allow air to circulate and complete the drying process.The tour of the dry storage area revealed an open brownie mix and a package of elbow pasta with no dating. The Dietary Manager confirmed that both items should have labels indicating the dates they were opened.The refrigerators revealed one pitcher of a yellowish fluid that the Dietary Manager stated was lemonade, a red substance in a clear, square container with a lid that the Dietary Manager stated was cranberry sauce, shredded vegetables with dressing in a clear, square container that the Dietary Manager stated was coleslaw, and diced, beige product which the Dietary Manager stated was diced chicken that were not labeled with what the items were or dates of production or expiration. The Dietary Manager confirmed that all items should be labeled with the item name, the date they were placed in the refrigerator, and the date they should be disposed of. Eleven packages of flour tortillas expired on 11/21/25, and a clear, square container of [NAME] expired on 11/14/25. The Dietary Manager confirmed that expired items should be removed and disposed of, not left in storage. She showed signage posted on the refrigerators indicating the task of labeling and dating items.The freezer revealed an open ravioli package that wasn't dated, and a box of hamburger patties was open to the air and not dated. The Dietary Manager confirmed that the items should be dated and stored in closed containers to protect their integrity per policy.2. A tour of the Kitchen on 12/10/25 at 1:15 PM with the Chef revealed an open, undated egg substitute carton in the refrigerator, which he confirmed should be dated when the seal is broken.The Chef was shown a picture provided by a resident showing a hot dog bun with a green-gray discoloration. He confirmed he was aware of the moldy bread, stating that the Kitchen was contacted during service on the day it was served, and the Kitchen staff remade the Resident's meal. The Chef said, It has been a struggle to balance the stock of bread, as the freezer space is limited.3. Per review of a facility policy Date Marking (dated 9/11/2020), states Date Marking systems are in place to reduce foodborne illness caused by, Listeria monocytogenes (a type of disease-causing bacteria which can have mild symptoms such as fever, muscle aches, nausea, vomiting, and diarrhea or more severe symptoms may include headache, stiff neck, confusion, loss of balance, and convulsions, FDA 1/16/25), a pathogen that continues to grow in refrigerated temperatures. The policy continues to state, Foods will be date marked with the name of the product, the date of production or opening. Refer to Quick Reference List (reference list of shelf lives of products) for discard date. Per interview on 12/10 at 3:54 PM, the Dietary Manager confirmed that the practice and facility policy require that items in storage be covered or placed in a container, labeled, and dated.Referencehttps://www.fda.gov/food/foodborne-pathogens/listeria-listeriosis