STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475029	A. Building B. Wing	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center for Living & Rehabilitation	160 Hospital Drive 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident did not develop an avoidable pressure ulcer for 1 of 3 residents in the sample (Resident #1). Findings include:Per record review Resident #1 was re-admitted to the facility on [DATE] after a short discharge to home. A Clinical admission Note reflects that s/he was admitted with a diabetic foot ulcer on her/his left heel. There is no mention of any wound being present on the right heel. Review of the Resident's care plan reveals a Focus dated 5/15/2025 of actual impairment to skin integrity. A Nurse Progress Note dated 6/2/2025 states This writer noted that resident had blood on right sock. Noted to have area to right heel. Supervisor made aware, and came to assess. Family made aware. Another Nurse Progress Note dated 6/2/2025 states resident has a open area on his right heel, supervisor [name omitted] assessed area, 5x5 cm broken blister noted red inner tissue surrounded by white soft tissue with dark pink edges, Slight odor. Resident #1 was transferred to the hospital later in the day on 6/2/2025 and returned to the facility on 6/5/2025. A Nurse Progress Note dated 6/5/2025 reflects that Resident #1 returned to the facility with a Right heel. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Stage 2 Pressure ulcer /injury - partial thickness skin loss with exposed dermis. Wound was present on admission. Length (cm): 7 Width (cm): 5 Depth (cm): 0.1. The right heel wound was present on readmission however, it had been identified in the facility on 6/2/2025, the day that the Resident transferred to the hospital. A Care Plan Focus of actual impairment to skin integrity lists an intervention dated 5/15/2025 lists interventions of Air mattress to bed (applied on admission--uses chronically due to wounds and high risk for wounds). On 6/7/2025 Bilateral heel booties on at all times--remove for skin care and transfers then reapply, was added to Resident #1's care plan. On 6/20/205 the care plan was revised to reflect Use cushion with sides to promote elevation of feet. Another Care Plan Focus for at risk for pain has interventions of Elevate Bil [bilateral] heels when in bed as desired. These protective interventions were not implemented until 6/7/2025, after the right heel pressure ulcer was identified. Per interview with the Director of Nursing on 6/30/2025 at 5:30 PM, she confirmed that the right heel wound had developed in the facility and that there were no documented interventions related to protecting the right heel from developing pressure ulcers prior to 6/2/2025.

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