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	12/16/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents' right to be free from physical and verbal abuse from another resident for 2 of 3 sampled residents (Resident #1 and Resident #2). The facility did not implement effective interventions to prevent recurrence after a prior altercation on 8/7/25, nor did it update care plans to address ongoing risk. On 9/17/25, Resident #1 sustained blunt trauma to the nose with bleeding after being struck by Resident #2 during a physical altercation, and Resident #1 expressed feeling unsafe and distressed in his/her home. This deficient practice resulted in actual physical harm and psychosocial harm. Findings include:Per record review, the Minimum Data Set (MDS, an assessment tool) dated 10/15/25 reveals that Resident #1 has a BIMS score (Brief Indicator for Mental Status, a test to check if thought processes are intact) of 15 out of 15, indicating cognition is intact. Resident #1 has diagnoses that include anxiety disorder and major depressive disorder. Resident #1 has a care plan focus dated 12/20/23 and revised on 11/14/25 that states, [Resident #1] is at risk for harm r/t [related to] behaviors that impact others. Will repeat statements at times and can become verbally and physically aggressive towards others at times. [Resident #1] can misinterpret situations and/or conversations and can demonstrate accusatory behaviors toward staff when [he/she] doesn't understand what is being communicated. Per record review, the MDS dated [DATE] reveals that Resident #2 has a BIMS score of 15 out of 15, indicating cognition is intact. Resident #2 has diagnoses that include anxiety disorder and bipolar disorder. Resident #2 has a care plan focus dated 3/5/25 and revised 11/14/25 that states, [Resident #2] has potential to be verbally aggressive and can make accusations towards staff r/t Ineffective coping skills, with an intervention dated 3/5/25 and revised 8/22/25 for, When [Resident #2] becomes agitated: If safe and feasible, gently guide [him/her] away from the source of distress or the current environment to a calmer, less stimulating are (e.g., quiet room, outside if appropriate); Engage in a conversation. If not safe to engage, ensure safety by calmly walking away and allowing [him/her] time to de-escalate before re-approaching and attempting to re-engage. Per record review, Resident #1 and Resident #2 had a physical incident between each other on 8/7/25. A facility reported incident (FRI) was reported to the state on 8/8/25 that describes an observed event where Resident #1 pushed his/her wheelchair into Resident #2 and kicked Resident #2. Resident #2 complained of discomfort to their leg. Per a record review, a facility reported incident (FRI) was submitted to the State Agency on 9/18/25, with an allegation of physical abuse related to a resident-to-resident altercation that occurred on 9/17/25 between Resident #1 and Resident #2. The report describes on 9/17/2025 The ADON (Assistant Director of Nursing) and NP (Nurse Practitioner) were at the opposite end of the hallway at the nursing station when they saw [Resident #1] approach [Resident #2]. Per their report, they heard words exchanged but could not distinguish exactly what was said. The tone appeared negative, so both the NP and the ADON immediately left the nursing station to intervene but before they reached the two residents, they saw [Resident #1] run [his/her] wheelchair more than once into [Resident #2's] wheelchair. [Resident #2] responded by striking [Resident #1] in the face with a closed fist (left hand). Upon assessment, [Resident #1's] nose was noted to bleed and [Resident #2] complained of left-hand discomfort.Per a record review, a 5-day investigation summary, including resident statements and staff witness statements, was submitted to the State Agency on 9/18/25. The summary corroborates that a physical altercation and threats occurred between Resident #1 and #2 on 9/17/25. There was nothing in the facility's investigation that revealed that staff attempted to separate the two residents prior to the event occurring.Per record review, a nursing progress note written on 9/17/25 stated the following, At approximately 1100 [Resident #2] was witnessed by this writer to be sitting in front of [his/her] room in his wheelchair . when another resident [Resident #1] who lives in another area came wheeling down the hallway toward this resident. Words were exchanged between the two residents, but this writer could not hear what was said. This writer began to run up the hallway to intervene just as the [Resident #1] started slamming [his /her] wheelchair into the side of this residents wheelchair. [He/she] slammed into this residents wheelchair 2 or 3 times before this resident [Resident #2] pulled back [his/her] fist and punched the other resident [Resident #1] in the face resulting in a bloody nose. This writer along with another nurse and NP had arrived at the incident and separated the residents at this time. [Resident #1] stated to [Resident #2] 'I am going to get a gun and shoot you, you fat piece of lard' over and over several times. The other resident was taken back to [his/her] room . [Resident #2] was assessed by RN and stated that [his/her] left hand/knuckles hurt.Per record review, a 9/17/25 NP progress note states, I

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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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 0657 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to review and revise the comprehensive care plans for 2 of 3 sampled residents (Residents #1 and #2) after significant changes in condition related to two resident-to-resident altercations. Despite an initial incident on 8/7/25 and a subsequent altercation on 9/17/25 resulting in Resident #1 sustaining blunt trauma to the nose and expressing fear and distress, the facility did not update either resident's care plan or Kardex to include interventions to prevent recurrence, such as separation or monitoring. Staff interviews confirmed reliance on informal redirection rather than documented interventions. This failure resulted in actual physical harm and psychosocial harm to Resident #1. Findings include:Per record review, the Minimum Data Set (MDS, an assessment tool) dated 10/15/25 reveals that Resident #1 has a BIMS score (Brief Indicator for Mental Status, a test to check if thought processes are intact) of 15 out of 15, indicating cognition is intact. Resident #1 has diagnoses that include anxiety disorder and major depressive disorder. Resident #1 has a care plan focus created on 12/20/23 and revised on 11/14/25 that states, [Resident #1] is at risk for harm r/t [related to] behaviors that impact others. Will repeat statements at times and can become verbally and physically aggressive towards others at times. [Resident #1] can misinterpret situations and/or conversations and can demonstrate accusatory behaviors toward staff when [he/she] doesn't understand what is being communicated.Per record review, the MDS dated [DATE] reveals that Resident #2 has a BIMS score of 15 out of 15, indicating cognition is intact. Resident #2 has diagnoses that include anxiety disorder and bipolar disorder. Resident #2 has a care plan focus created on 3/5/25 and revised on 11/14/25 that states, [Resident #2] has potential to be verbally aggressive and can make accusations towards staff r/t Ineffective coping skills, with an intervention dated created on 3/5/25 and revised on 8/22/25 for, When [Resident #2] becomes agitated: If safe and feasible, gently guide [him/her] away from the source of distress or the current environment to a calmer, less stimulating are (e.g., quiet room, outside if appropriate); Engage in a conversation. If not safe to engage, ensure safety by calmly walking away and allowing [him/her] time to de-escalate before re-approaching and attempting to re-engage. Per record review, Resident #1 and Resident #2 had a physical incident between each other on 8/7/25. A facility reported incident (FRI) was reported to the state on 8/8/25 that describes an observed event where Resident #1 pushed his/her wheelchair into Resident #2 and kicked Resident #2. Resident #2 complained of discomfort to their leg. Per record review, a facility reported incident (FRI) was submitted to the State Agency on 9/18/25, with an allegation of physical abuse related to a resident-to-resident altercation that occurred on 9/17/25 between Resident #1 and Resident #2. Resident #1 ran his/her wheelchair into Resident #2, multiple times. Resident #2 responded by punching Resident #1 in the nose while stating, I am going to get a gun and shoot you, you fat piece of [NAME]. As a result of the 9/18/25 incident, Resident #1 was taking to the emergency department for blunt trauma to the nose with a bleed. A 9/17/25 NP progress note was clearly angry and distressed by the altercation. On 12/15/25 at 12:55 PM, Resident #1 stated that s/he does not feel safe at the facility. See F600 for more information.Per interview with LNA #1 (Licensed Nursing Assistant) at 4:08 PM on 12/15/25, the Kardex (a quick reference tool for referencing patient needs) tells staff what to look for regarding specific residents. LNA #1 was not aware of Resident #1 having trouble with any specific residents.Per an interview with the Unit Manager at 4:10 PM on 12/15/25, the facility's strategy to keep Resident #1 and Resident #2 separated is to try to keep them apart. The Unit Manager stated that information should be care planned and in the Kardex. Per record review, there was nothing to indicate keeping Resident #1 and Resident #2 apart in either resident's Kardex or in either resident's care plan.Per interview with the DON (Director of Nursing) at 4:18 PM on 12/15/25, the facility attempts to keep Resident #1 and Resident #2 separated by kind of just redirecting them. The DON confirmed there is nothing specific in Resident #1 or Resident #2's care plans or Kardex with regard to keeping them apart or protecting them from each other, following either of the two altercations.