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	12/30/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews, the facility failed to ensure that 1 of 4 residents in the sample were treated with dignity and respect (Resident #1). Findings include:Per observation on 12/30/2025 at approximately 4:15 PM, Licensed Practical Nurse #1 (LPN) was observed answering Resident #1's call bell. Resident #1 requested pain medication. LPN #1 addressed the resident as Boo three different times within their interaction.Per interview with Resident #1 on 12/30/2025 at 4:34 PM, Resident #1 stated my name is (proper name omitted), it's not Boo and I don't know why (LPN #1) would call me that. Per interview with LPN #1 on 12/30/2025 at 4:52 PM, they stated Resident #1"s nickname is not Boo it's just a figure of speech and it's what I call everybody.Per interview on 12/30/2025 at approximately 7:45 PM with the Administrator (ADM), she stated that it is not appropriate to address residents with terms of endearment and that staff should address the residents by their preferred name or pronoun.

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
	475029	A. Building B. Wing	12/30/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based upon observations, interviews, and record review, the facility failed to ensure adequate pain control was provided for 1 of 4 sampled residents (Resident #1). Findings include:Per record review, Resident #1 was admitted to the facility with diagnoses that include chronic pain syndrome and osteoarthritis (a diagnosis affecting joint cartilage causing pain swelling and stiffness of the affected joints). Resident #1 has a BIMS [Brief Interview for Mental Status] score of 14, dated 10/7/25, indicating cognitive function is intact.Per observation on 12/30/2025 at 3:10 PM, Resident #1 vocalized with increased volume help. At 3:13 PM, LNA (Licensed Nursing Assistant) #1 entered the room. Resident #1 stated that they wanted to get into bed and that their back hurt. LNA #1 told Resident #1 they needed to stay up in their chair for dinner.Per interview with Resident #1 at 3:46 PM on 12/30/2025, s/he stated that s/he had asked a staff member to lie down in bed because of their back pain and that s/he was told s/he needed to stay up for dinner. Per observation at 3:53 PM, three staff members wheeled the Hoyer lift [equipment to lift and transfer a person] entered Resident #1's room. S/he was transferred to bed at that time. Resident #1 stated pain in their lower back was a 9 out of 10 and that they receive Tylenol for pain management but they won't bring it. Resident #1 pushed the call bell at 4:10 PM to notify the nurse that they would like pain medicine.Per observation on 12/30/2025 at 4:15 PM, LPN #1 (Licensed Practical Nurse) entered Resident #1's room to address the call bell. LPN # 1 told Resident #1 they do not have PRN (as needed) pain medication and that they receive scheduled Tylenol that is not due until 8:00 PM that evening. LPN #1 asked Resident #1 to rate their pain on a scale of 1-10 and describe the location. Resident #1 stated their pain was a 9 out of 10 in their lower back and that the scheduled Tylenol does not seem to be managing the pain. LPN #1 stated they'd notify the provider about Resident #1's concerns of Tylenol not appropriately managing their pain, and that the provider would see Resident #1 on rounds the following day to address this. LPN #1 also stated to Resident #1 they have a topical pain relief cream that will be applied at bedtime. The LPN did not offer any non-pharmacological options (back rub, meditation, music, aromatherapy, etc.) to help with Resident #1's current pain. Per record review, a Progress note from LPN #1 entered at 4:15 PM on 12/30/2025 stated: Summoned to res [resident] room, res c/o [complaint of] pain to lower back and lower leg. MAR [Medication Administration Record] reviewed. No PRN pain medications ordered. educated res that [s/he] have Tylenol scheduled. Res stated Tylenol is ineffective. Message sent over to NP / MD. Per review of Resident #1's orders, an order from the provider dated 7/30/2024 with an indefinite end date states May use facility standing orders. Per review of a document titled Center for Living and Rehabilitation Standing Orders revised/reviewed on 11/21/2024 a standing order for a topical pain relief treatment read Muscle rub: apply topically to affected area every two hours as needed, notify provider if ineffective. Resident #1 has an order that states Acetaminophen Oral Tablet Extended Release 650 milligrams every 8 hours for back pain Notes: FOR PRN PAIN USE - Ensure that Non-Pharmacological Interventions are in Additional Directions and Supplemental documentation as follows: Nonpharmacological Interventions 1. Reposition 2. Back rub 3. Music 4. Diversional activity. At the time of Resident #1's pain assessment, LPN #1 did not offer nonpharmacological interventions, or standing order for topical pain relief ointment.Per interview at 7:40 PM with the Director of Nursing (DON) and Administrator (ADM), they confirmed that an assessment revealing a pain level of 9 on a scale of 1-10 should be addressed timely and before the provider rounds the following day. They also confirmed nonpharmacological approaches should be offered/implemented for pain management.

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	12/30/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview, the facility failed to ensure that of 1 of 4 sampled residents had access to the call bell in their room (Resident #1). Findings include:Per record review, Resident #1 was admitted with diagnoses that include chronic pain syndrome, morbid obesity, lymphedema, (Lymphedema refers to tissue swelling caused by fluid that's usually drained through the body's lymphatic system. It most commonly affects the arms or legs, and severe cases of lymphedema can affect the ability to move the affected limb), and osteoarthritis (a diagnosis affecting joint cartilage causing pain swelling and stiffness of the affected joints). Review of Resident #1's Minimum Data Set Assessment (MDS) with a reference date of 10/07/2025 revealed Resident #1 has a BIMS (Brief Interview for Mental Status) score of 14 indicating Resident #1 is cognitively intact.Per observation on 12/30/2025 at 3:10 PM Resident #1 was sitting in a wheelchair in their room, facing the window and vocalized with increased volume help. The call bell was observed pinned on the top sheet of the resident's bed out of their reach.Per interview with Resident #1 at 3:46 PM on 12/30/2025, they stated s/he was brought to their room after bingo and requested to go to bed, staff said they would be right back. Resident stated that s/he could not reach the call bell for assistance and had to use their cell phone to call a friend and ask their friend to call the facility's nurse's station. Resident #1 stated that is the only reason someone came to their room to give them their call bell and turn their chair around. Resident #1 was observed during interview facing the door to the hallway, call bell hanging over the foot board where they could reach it while sitting in the wheelchair at the foot of the bed.Per interview with Licensed Practical Nurse (LPN) #1 on 12/30/2025 at approximately 4:29PM, they stated that Resident #1 is impatient so s/he provided re-education to the resident about their requirement for two-person assistance with transfers. LPN #1 confirmed that resident's friend/family member called the facility to have staff go into the resident's room and assist the resident.