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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center for Living & Rehabilitation	160 Hospital Drive Bennington, VT 05201

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 52048 Based on interview and record review, the facility failed to ensure that the Residents' power of attorney (POA) was assisted with developing advanced directives consistent with their wishes for 1 of 40 residents in the sample (Resident #40). Findings include: Per record review Resident #40 signed a notarized advanced directive on 11/22/16. The notarized advanced directive states If I suffer a condition from which there is no reasonable prospect of regaining my ability to think and act for myself, I want only care directed to my comfort and dignity, and I authorize my agent to decline and terminate all treatment (including artificial nutrition and hydration) the primary purpose of which is to prolong my life. If the situation should arise in which I am in a terminal state and there is no reasonable expectation of my recovery, I direct that I be allowed to die a natural death and that my life not be prolonged by extraordinary measures. I do, however, ask that medication be mercifully administered to me to alleviate suffering, even though this may shorten my remaining life According to the advanced directive a family member is named as the Resident's power of attorney (POA). Further record review reveals a Clinicians Order for Life Sustaining Treatment (COLST) form that was signed and dated by a facility clinician on 1/15/25 that states that Resident #40 is a Full Code. This COLST form is not signed by the Resident or their POA. An additional Clinicians Order for Life Sustaining Treatment COLST form dated 1/21/25 from a hospitalization is signed by a Clinician, but not the Resident or POA. Resident #40's advanced directive and a Clinicians Order for Life Sustaining Treatment COLST do not match and the current COLST does not not reflect the Resident's previous wishes. There is no documented evidence that the Resident or POA was consulted regarding the change to full code status. A physician note dated 3/3/25 states will need to review if [the Resident] has designated a HCP [health care proxy] and discuss goals of care and code status in the context of his/her recent decline. [S/he] remains a Full Code at this time but had previously expressed that living dependent on others was [her/his] worst fear. A physician note dated 4/14/25 states that Resident #40 is a Full code, but unable to continue to make medical decisions due to lack of insight into advanced dementia. (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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 4/30/25 at 11:39 AM, she confirmed that the physician's notes from 3/3/25 and 4/14/25 identified that the Resident was a full code and that there was a need to reassess. The DON also confirmed that the COLST wasn't signed by Resident #40 or her/his POA. The DON reported that they hadn't communicated to the family about it as they don't always agree, and the facility was hoping that Resident #40 would become more alert and orientated and be able to decide for themselves.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 29776 Based on interview and record review, the facility failed to ensure 3 residents [Residents #15, #80, and #99] of 5 sampled residents received adequate supervision and create and implement effective, timely interventions that would reduce the likelihood of future falls. Findings include: 1). Review of Resident #15's medical record reveals the resident is diagnosed with Parkinson's Disease [a progressive movement disorder of the nervous system leading to symptoms that include problems with movement, stiffness, and impaired balance], difficulty walking, cataracts, muscle weakness, and bipolar disorder. Review of Res.#15's Care Plan reveals the Resident is identified as at risk for falls related to Gait/balance problems; medications; anxiety; visual deficit; urine retention, and disease process secondary to Parkinsons, bipolar disorder. Review of the facility's Fall Prevention and Protocol policy [modified 4/26/24] includes every resident admitted to [the facility] will have a Fall Risk Evaluation .after each fall. Additionally, per interview with the Director of Nursing [DON] on 4/30/25 at 9:30 AM, the DON stated that after each fall, a resident's Care Plan is updated and revised to include new interventions to prevent future falls. Review of the facility's Fall Risk Evaluation tool lists if the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Per record review, after a fall on 2/1/25, Resident #15's Fall Risk score was 22. Per review of Resident #15's medical record, on 4/3/25, nursing was Called to room for fall. [Resident #15] was sitting on the floor parallel to the bed facing the foot of the bed. Right arm on the bed side, left arm holding on to the right side of [h/her] wheelchair which was parked close to the bed as [s/he] was attempting to transfer into bed. I was trying to get in the bed. [H/her] pants were slightly down below [h/her] buttocks as well as the brief which was completely saturated with urine and feces . Staff report [s/he] had been refusing care all evening. Per review of Resident #15's medical record and Care Plan on 4/30/25, there was no Fall Risk Evaluation completed after the fall on 4/3/25, and no revision or interventions added to Resident #15's Care Plan to prevent future falls. Per interview with the Director of Nursing [DON] on 4/30/25 at 9:30 AM, the DON confirmed Resident #15's Care Plan should have been updated and revised to include new interventions, and a Fall Risk completed after the fall on 4/3/25 but was not. 50431 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Per record review of Resident #80's medical record reveals that Resident #80 had medical diagnoses of hemiplegia and hemiparesis (weakness and/or paralysis) following a cerebral infarction (a stroke) affecting his/her right dominant side, dysphagia (difficulty swallowing), aphasia (a communication disorder that affects how individuals produce and understand language), and paroxysmal atrial fibrillation (an irregular heartbeat). Per record review of Resident #80's care plan states, [Resident #80] has had actual falls r/t [related to] gait/balance problems, psychoactive drug use, right side weakness, and increased behaviors after family leaves. Most falls out of bed are to [his/her] right. Per record review of the facility's Fall Prevention and Protocol policy [modified 4/26/24] states, Every resident admitted to [the facility] will have a fall risk evaluation .after each fall. Per record review of a nursing progress note written on 4/23/25 states, At approximately 330 am [sic], CNA [Certified Nursing Assistant] notified other CNA and myself that the resident was lying face forward on the floor. [Resident #80] had .a red mark above [his/her] left brow and on [his/her] upper left cheek were noted. Per record review, a fall risk assessment was not completed for Resident #80 after the fall on 4/23/25. Resident #80 sustained a subsequent fall on 4/29/25. Per record review of Resident #80's progress notes, Resident #80 sustained falls on 3/17/25, 4/15/25, 4/23/25, and 4/20/25. Per record review of the facility's Fall Prevention and Protocol-CLR policy [no revised/reviewed date] states, a. Document appropriate interventions on the resident/patients care plan related to fall prevention. Examine previous fall patterns if known and document this on care plan well. B. During regularly scheduled reviews of the care plan, ensured that all interventions related to prevention of falls remain appropriate. Per record review of Resident #80's care plan, there are no additional interventions for the falls occurring on 4/23/25. On 4/30/25 at 11:26 AM the DON [Director of Nursing] confirmed that the resident's care plan needs to be updated after every fall. 3. Per record review of a fall note dated 3/16/25 states, Resident [Resident #99] lying on the floor on [his/her] right side facing the doorway with [his/her] back to the bed .Resident was lifted by hoyer back into bed. On 4/30/25 at 11:26 AM the DON [Director of Nursing] confirmed that the resident's care plan needs to be updated after every fall. Per record review of Resident #99's care plan, there are no additional interventions on Resident #99's care plan after the falls occurring on 3/16/25. On 4/30/25 at 11:26 AM the DON [Director of Nursing] confirmed that the residents' care plan needs to be updated after every fall.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 29776 Based on interview and record review, the facility failed to ensure that a resident with a nutritional problem was given nutritional supplements and appetite stimulants as ordered by a physician for one resident [Resident #106] of 7 sampled residents. Findings include: 1. Per review of Resident #106's medical record, the resident's diagnoses include cancer of the prostate and bone, and difficulty swallowing. Review of the resident's Care Plan reveals the resident is identified as at risk for malnutrition as I have increased nutritional needs with cancer treatment and altered skin integrity, poor appetite and intake, need for protein/nutritional supplement. Care Plan interventions include Provide me with my supplement as ordered: 8oz House Shake, 8oz Boost VHC and provide further nutrition interventions. Review of Physician Orders for Resident #106 include House shake in the afternoon for at risk for malnutrition and Megestrol Acetate Oral Suspension-Give 10 milliliters by mouth in the morning for Appetite stimulant. Review of Resident #106's Medication Administration Record [MAR] for April 2025 reveals the resident did not receive the Megestrol Acetate Oral Suspension medication for appetite stimulation as ordered on 4/20, 4/22, 4/23, 4/24, & 4/28/25. Per review of Nursing Progress notes for those dates, the medication is documented as on order or unavailable. Further record review reveals a Pharmacy email correspondence dated 4/22/25 reporting that the Megestrol Acetate Oral Suspension medication was delivered on 4/17/25 and was available. Review of Resident #106's Medication Administration Record [MAR] for April 2025 also includes the physician ordered House Shake nutritional supplement not administered on 4/10, 4/18, 4/23, 4/24, 4/25, & 4/26/25. Review of Nursing Progress Notes reveal the House Supplement listed on those dates as not available. An interview was conducted with the Dietary Manager on 4/30/25 at 1:24 PM. The Dietary Manager stated that House Shakes are always available and are made daily in the kitchen and are distributed on the resident units at 10:00 AM daily. Review of Resident #106's medical record reveals the resident underwent a 6.9 pound weight loss from April 1st to April 28th, 2025 [a loss of 4.3% of their total body weight]. An interview was conducted with the Director of Nursing [DON] on 4/30/25 at 9:30 AM. The DON confirmed that both the Megestrol Acetate Oral Suspension medication and House Supplement were available on the listed dates but were not administered as ordered, with the resident suffering from a 4.3% weight loss during this time period.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 50431 Based on interview and record review the facility failed to maintain drug regimen reviews for one out of five sampled residents (Resident #88). Findings include: Per record review, Resident #88 had MRR [Medication Regimen Review] (a monthly review by the pharmacist for any medication recommendations made based on safety and patient specific diagnoses). Resident #88 had medication recommendations made from the pharmacist in June 2024, August 2024, September 2024, October 2024, December 2024, February 2025, and March 2025. Per record review of Resident #88's chart the resident did not have copies of MRRs for the months of June 2024, August 2024, and September 2024. Per record review of Pharmacy Drug Regimen Review-CLR policy [no revised or reviewed date] states, Facility: 1. Shall maintain all Drug Regimen Review recommendations along with prescriber's responses in an easily retrievable location for presentation to surveyors, upon request. 2. Shall file or drug review recommendations with the permanent medical record for each resident after one year. 3. Shall file the findings under the Physicians Order Section. An interview was conducted with the Director of Nursing, RN#1, and the MDS [Minimum Date Set] Coordinator on 4/29/25 at 4:33 PM. The DON, MDS Coordinator, and RN#1 confirmed there were no MRRs for the months of June 2024, August 2024, and September 2024 in Resident #88's chart. The facility did not have the MRRs in the paper chart and were not maintained in the facility to be readily available for review.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43524 Based on observation, interview, and record review, it was determined that the facility failed to ensure drugs and biologicals were stored in accordance with currently accepted professional principles for 3 of the 4 medication carts observed, and 2 of 2 medication storage rooms observed. Findings include: 1. During observations on 4/30/25 at approximately 9:40 AM on the [NAME] Unit, the nurse poured all the residents medications and put them all in the top drawer of the medication cart and stated he was going to get water. He walked away from the medication cart with the water pitcher and left 4 blister packs of medications, 3 bottles of OTC (over the counter) medications, and a bottle of metamucil on the top of the medication cart. Per interview with the nurse on 4/30/25 at approximately 9:45 AM, he confirmed that he had left these medications on top of the medication cart unsupervised and improperly stored. 2. During observation on 4/30/25 at approximately 3:15 PM, the medication storage room on the [NAME] Unit revealed the following issues: (5) DB Bactec Lytic/10 Anaerobic/F Culture vials (used for performing blood cultures) with expiration dates of 2/12/25 and (4) BD Bactec Plus Aerobic/F Culture vials with an expiration date of 2/24/25. Per interview on 4/30/25 at approximately 3:20 PM, the nurse working on the [NAME] Unit confirmed the culture vials had expired and were in the medication storage room and available for use. 3. Per observation on 4/30/25 at 4:57 PM of the medication storage room on [NAME] Unit a jar/container of Vanicream 16 oz was noted to have expired on 2/2025. Per interview on 4/30/25 at approximately 5:00 PM, the nurse on the [NAME] Unit confirmed the Vanicream had expired and was available for use. 4. Observation at approximately 4/30/25 5:05 PM of a [NAME] Hall medication cart revealed an open 10 oz bag of peanut butter pretzels - the LPN went to the med cart and removed them and put them in a room behind the nurses station. Review of the medication cart revealed a blue pill cutter with a white powdery substance and white small particles/crumbs on the blade and within the cutting device, the LPN working this cart, confirmed that the pill cutter needed to be cleaned and the substances noted were pill/medication debris; (21) tablets of Pravastatin Sodium 40 mg tablets with an expiration date of 3/31/25; (30) tablets of Omeprazole DR 20 mg capsules with an expiration date of 12/15/25; (29) capsules of Benzonatate 100 mg capsule with expiration date of 4/14/25; (30) tablets of Meclizine 12.5 mg capsules with an expiration date of 4/14/25; (13) capsules of Biotin 10,000 mcg stock medication with an unknown expiration date due to it being rubbed off. Interview on 4/30/25 at approximately 5:15 PM with the Unit Manager confirmed the above findings of expired medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Observation of a [NAME] Unit medication cart on 4/30/25 at approximately 5:25 PM revealed the following expired medications: (10) tablets of Vitamin D3 50 mcg (2000 IU) with an expiration date of 4/4/25; (10) tablets of Levocetirizine 5 mg with an expiration date of 6/28/24; (10) tablets of Levocetirizine 5 mg with an expiration date of 7/10/24; (16) 1/2 tablets of Meclizine 25 mg for with an expiration date of 10/29/24; (10) 1/2 tabs of Meclizine 25 mg with an expiration date of 4/20/25; (10) tablets of Ondansetron HCL 4 mg with an expiration date of 3/31/25; (30) 1/2 tablets of Meclizine 25 mg with an expiration date of 4/20/25; Interview on 4/30/25 at approximately 5:40 PM with the Unit Manager confirmed the above findings of expired medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29776 Based on observation, interview, and record review, the facility failed to ensure infection control measures were implemented regarding residents on isolation precautions and during a medication pass. Findings include: 1.) Per observation on 4/28/25 at 12:30 PM, signage posted outside of room M105 included an infection control STOP sign, instructing anyone entering the room to check with staff before entering and follow appropriate precautions. Below the STOP sign were instructions for Staff to follow contact precautions. The contact precautions listed included hand hygiene, gowns, gloves, and clean equipment after use. Review of Physician Orders for the single resident in room M105 included Contact precautions every shift with a start date of 5/8/24. Per observation on 4/28/25 at 12:38 PM, a male nurse was observed in resident room M105. The nurse was observed picking up and handing the resident's assorted personal items, then adjusting the curtains around the resident's bed before leaving the room. The nurse was not wearing gloves or a gown during any of the resident interactions. The nurse did not sanitize his hands after leaving the contact isolation room and was observed pushing a lunch tray cart down the hall to room M113, picking up a lunch tray from the cart, and entering room M113 with the tray. Per observation on 4/28/25 at 4:59 PM, a male and female staff member entered resident room M105. The resident reported having an issue with h/her right leg, and both staff members were observed touching both the resident's right and left leg with their bare hands. Neither staff member was observed wearing a gown. The male staff member exited the room, and another female staff member entered. The second female staff member was observed removing bed linen from the resident's bed. Both female staff members were observed exiting resident room M105 with used bed linens with their bare hands. Neither staff member was observed wearing a gown. Neither staff were observed using hand hygiene after exiting the contact isolation room and carrying the used linens down the hall. An interview was conducted with the facility's Infection Preventionist [I.P.] on 4/30/25 at 12:00 PM. The I.P. stated that contact isolation requires Personal Protective Equipment [PPE] which includes gowning and gloves for all resident contact, along with hand hygiene after resident contact and removing PPE. The I.P. confirmed the observations made on 4/28/25 in resident room M105 demonstrated a break in infection control preventions and increased risk in spreading infection to other residents. 43524 2. During observation on 4/29/25 at approximately 9:30 AM of medication passes on the [NAME] Unit, a male nurse pouring/pushing tablets from a blister packet (a form of tamper resistant packaging where an individual pushes individually sealed tablets through the foil in order to take the medication) for Resident #108 into his ungloved hand and then placed these medications into a medication cup and administered them to the resident. The nurse did not perform hand hygiene prior to preparing Resident #482's medications in which he again poured/pushed tablets from a blister packet directly into his ungloved hand and then placed these medications into a medication cup and administered them to the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 4/30/25 at approximetly 9:45 AM, the nurse confirmed that he had poured medications from the blister pack for 2 residents into his ungloved hand. He stated that it was his understanding he was not allowed to wear gloves in the hallway. The nurse confirmed that he did not perform hand hygiene between medication administration for Resident #108 and Resident #482.