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	04/08/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to provide supervision related to smoking for 1 of 1 sampled residents (Resident #15). Additionally, the facility failed to monitor the storage of Resident #15's lighter and cigarettes. This is a repeat deficiency, with the violation being cited during the past two recertification surveys dated 4/30/25 and 3/27/24. Findings include:Per record review, Resident # 15 is care planned for smoking, revised on 7/28/25. Resident #15's care plan goal is to not smoke without supervision. Care plan interventions include educating the resident on the facility's policy about smoking locations, times, and safety concerns.Per observation, at approximately 12:55PM on 4/7/26 a person is sitting in a wheelchair, outside the entrance to the facility smoking a cigarette. There are no observed staff members outside.Per interview with the Receptionist at 12:57 PM on 4/7/26, the resident outside was Resident #15, and s/he is permitted to sit outside without staff supervision.Per interview 4/7/26 at approximately 1:03 PM with the Assistant Director of Nursing (ADON), they stated that Resident #15 used to smoke and had recently quit. S/he explained Resident #15 signed the facility's admission agreement that states the facility is non-smoking and residents will not smoke while living there. Resident #15 has been seen in the past on several occasions by staff members outside smoking and returning to the facility smelling like smoke. The ADON confirmed the facility has been working with the resident to assist with smoking cessation utilizing lollipops and nicotine replacement. The ADON confirmed there are 7 residents that wander and 26 residents with a diagnosis of dementia on Resident #15's unitPer interview on 4/7/26 at 1:10 PM with the Administrator, Resident #15 used to smoke and had quit on 4/4/26. S/he confirmed that the facility was aware that Resident #1 was smoking on facility grounds prior to 4/4/26 with supervision of staff and Resident #15 has not had a smoking safety assessment. Additionally, Resident #15 manages/stores their cigarettes and lighters/ignition devices independently as they are their own person and alert and oriented.Per interview with Resident #15 at approximately 1:30 PM on 4/7/26 they are trying to quit smoking, but it is challenging. S/he expressed it is a trigger when staff provide care smelling like smoke. Resident #15 stated the facility allows them to go outside to smoke independently without staff supervision. S/he stated s/he keeps their cigarettes and lighter in their shirt pocket or nightstand drawer.

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