VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

November 14, 2023

Ms. Shannon McHale, Administrator
Crescent Manor Care Ctrs
312 Crescent Blvd
Bennington, VT 05201-0170

Provider #: 475033

Dear Ms. McHale:

Enclosed is a copy of your acceptable plans of correction for the Life Safety Code survey conducted on **October 5, 2023**. Please post this document in a prominent place in your facility.

We will follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

tammy wehmeyer

Tammy Wehmeyer
Administrative Services Manager

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475033	A. BUILDING 01 B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT MANOR CARE CTRS	312 CRESCENT BLVD BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The Division of Fire Safety completed an unannounced onsite Life Safety Code inspection on 10/5/23. Entry and exit interviews were conducted with the Facilities Director and the facility Administrator. The following violations were identified.	K 000	**Tags K 222-K 918 POC accepted on 11/14/23 by M. Steele/T. Wehmeyer**	
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location	K 222	**K-222 Egress Doors** **I. The following actions were accomplished for the residents identified in the sample**: There were zero residents identified in the sample. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** There were zero residents affected by this deficient practice. Residents residing on the Memory Care Wing have the potential to be affected by this deficient practice in the event of an emergency. **III. The following system changes will be implemented to assure continuing compliance with regulations:** The Memory Care Wing double doors were set to provide push to egress protection. Signage was placed indicating push to exit, doors can be opened in 15 seconds. Countryside Alarms conducted an inspection of the smoke detection system on 10/27/23. All smoke zone doors were determined to provide release through activation of the smoke detection or sprinkler systems.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: LNHA | (X6) DATE: 11/09/23

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.

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K 222	Continued From page 1 within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on a walkthrough of the premises on 10/5/23 with the Facilities Director, survey activities determined that: 1) Memory care wing double doors do not provide push to egress protections; or signage "Push to exit, doors can be opened in 15 seconds".	K 222	The unapproved bolts and hardware which limited egress to the corridor fire exits on the double door in the small Activity Room were removed on 10/05/2023. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** The Memory Care Wing double doors were added to the weekly door/alarm check schedule for Preventative Maintenance. Inspection and Maintenance of the smoke detection system will be scheduled annually with a technically qualified person on file with the Division of Fire Safety. Results of the audits will be reviewed in the QAPI committee meeting x 4 months for further resolution if needed. **Completion Date: 11/15/2023** **Responsibility: Director of Environmental Services**	

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	475033	A. BUILDING **01** B. WING _____	**10/05/2023**

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K 222	Continued From page 2 2) Survey activities were unable to determine if this and other smoke zone doors are arranged to unlock on sprinkler and detection activations. 3) The double door in small Activity room in the North Corridor has unapproved bolts and hardware which limit egress to the corridor fire exits.	K 222	**K-223 Doors with Self-Closing Devices** **I. The following actions were accomplished for the residents identified in the sample**: There were zero residents identified in the sample. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** There were zero residents affected by the deficient practice. All residents have the potential to be affected by this deficient practice in the event of an emergency. **III. The following system changes will be implemented to assure continuing compliance with regulations:** Countryside Alarms conducted an inspection of the smoke detection system on 10/27/23. All smoke zone doors were determined to provide release through activation of the smoke detection or sprinkler systems. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** Inspection and Maintenance of the smoke detection system will be scheduled annually with a technically qualified person on file with the Division of Fire Safety. The system will be tested during the required Fire Drills scheduled for emergency preparedness. Results of the inspection/drills will be reviewed in the QAPI committee meeting x 4 months for further resolution if needed. **Completion Date:** **10/27/2023** **Responsibility: Director of Environmental Services**	
K 223 SS=C	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on a walkthrough of the premises on 10/5/23 with the Facilities Director, survey activities determined that: Smoke zone doors in corridors cannot be determined to provide release through activation of the smoke detection or sprinkler systems.	K 223		
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101	K 341		

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K 341	Continued From page 3 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on a walkthrough of the premises on 10/5/23 with the Facilities Director, survey activities determined that: 1) No documentation was available on site at the time of survey to demonstrate maintenance and testing of the required smoke detection system; no report by a Technically qualified person was on file with the Division of Fire Safety. 2) Sensitivity testing of the Smoke detection system has not occurred throughout since Quarter 1 of 2021.	K 341	**K-341 – Fire Alarm System - Installation** **I. The following actions were accomplished for the residents identified in the sample:** There were zero residents identified in the sample. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** There were zero residents affected by the deficient practice. All residents have the potential to be affected by this deficient practice in the event of an emergency. **III. The following system changes will be implemented to assure continuing compliance with regulations:** Countryside Alarms conducted an inspection of the smoke detection system on 10/27/23. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** Inspection and Maintenance of the smoke detection system will be scheduled annually with a technically qualified person on file with the Division of Fire Safety. Results of the inspection will be reviewed in the QAPI committee meeting x 4 months for further resolution if needed.	
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall	K 741	**Completion Date:** **10/27/2023** **Responsibility: Director of Environmental Services**	

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K 741	Continued From page 4 include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on a walkthrough of the premises on 10/5/23 with the Facilities Director, survey activities determined that: 1) A smoking policy has been adopted, but "no smoking" signs were not evident at entrances to the facility. Smoking policy has not been written for patient's use during inclement weather. 2) Staff smoking area outside the building needs to be policed with proper extinguishing receptacles more than 35' away from the Staff	K 741	**K-741 Smoking Regulations** **I. The following actions were accomplished for the residents identified in the sample:** There were zero residents identified in the sample. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** There were zero residents affected by the deficient practice. All residents have the potential to be affected by this deficient practice in the event of an emergency. Employee Smoking Policy was reviewed and revised. Resident Smoking Policy was reviewed and revised to address use during inclement weather. **III. The following system changes will be implemented to assure continuing compliance with regulations:** Employees were educated on the revised Employee Smoking Policy and the Resident Smoking Policy. "No Smoking" signs were placed at the entrances to the facility. Proper extinguishing receptacles were placed more than 35' away from the Staff Entrance. Employee smoking area was cleared of debris. Receptacles in Huntington's smoking area were moved further from the patio.	

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K 741	Continued From page 5 entrance. 3) Huntington's patients who smoke were supervised, however receptacles should be moved further from the patio.	K 741	**IV. The facility's compliance will be monitored utilizing the following quality assurance system:** The Employee Smoking Area will be inspected daily x 2 weeks and weekly thereafter to ensure the area remains clear of debris and that the receptacles are at least 35' from the staff entrance. The Huntington's Smoking Area will be inspected daily x 2 weeks and weekly thereafter to ensure that the smoking receptacles are moved further from the patio. Results of the audits will be reviewed in the QAPI committee meeting x 4 months for further resolution if needed. **Completion Date:** **11/15/23** **Responsibility: Director of Environmental Services** **K-918 Electrical Systems – Essential Electric System Maintenance and Testing** **I. The following actions were accomplished for the residents identified in the sample:** There were zero residents identified in the sample. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** There were zero residents affected by the deficient practice.	
K 918 SS=B	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power	K 918		

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K 918	Continued From page 6 source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a walkthrough of the premises on 10/5/23 with the Facilities Director, survey activities determined that: No Generator Set Emergency lighting is supplied in the event of power/transfer switch failure for the required Emergency egress/ lighting systems.	K 918	**III. The following system changes will be implemented to assure continuing compliance with regulations:** Generator Set Emergency Lighting was installed. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** The Generator Set Emergency Lighting was added to the weekly generator preventative maintenance schedule. Results of the preventative maintenance checks will be reviewed in the QAPI committee meeting x 4 months for further resolution if needed. **Completion Date:** **11/15/23** **Responsibility: Director of Environmental Services** **K-353 Sprinkler System – Maintenance and Testing** **I. The following actions were accomplished for the residents identified in the sample:** There were zero residents identified in the sample. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** There were zero residents affected by the deficient practice.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475033	MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING	DATE SURVEY COMPLETE: 10/5/2023

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a walkthrough of the premises on 10/5/23 with the Facilities Director, survey activities determined that: Sprinkler System A TQP sprinkler system report of 2/14/2023 reports that there are "outdated dry sidewalls" at the entrance. All residents have the potential to be affected by this deficient practice in the event of an emergency. **III. The following system changes will be implemented to assure continuing compliance with regulations:** The "outdated dry sidewalls" at the entrance noted on the sprinkler system report of 02/14/2023 were replaced. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** Results of the sprinkler inspection report will be reviewed in the QAPI committee meeting x 4 months for further resolution if needed. **Completion Date:** **11/15/23** **Tag K 353 POC accepted on 11/14/23 by M. Steele/T. Wehmeyer** **Responsibility: Director of Environmental Services**

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The above isolated deficiencies pose no actual harm to the residents