

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 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

PRINTED: 11/07/2023 FORM APPROVED DMB NO 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|--|--------|---|--------------------|----------------------------|
| | | 475033 | B. WNG_ | B. WNG | | 10/05/2023 | |
| NAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD BENNINGTON, VT 05201 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| K 000 | INITIAL COMMENTS | | K | 000 | | | |
| | on 10/5/23. Entry and conducted with the Fa | ife Safety Code inspection | | | Tags K 222-K 918 POC accepted or by M. Steele/T. Wehmeyer K-222 Egress Doors | n 11/14/2 | 23 |
| | Egress Doors CFR(s): NFPA 101 | | K2 | 222 | The following actions were accomplished for the residents identifing the sample: | | |
| | equipped with a latch | eans of egress shall not be or a lock that requires the | | | There were zero residents identified in th sample. | е | |
| | using one of the followarrangements: | om the egress side unless ving special locking R SECURITY THREAT | | | II. The following corrective actions wi implemented to identify other resident who may be affected by the same practice: | ts | |
| | Where special locking clinical security needs | g arrangements for the | | | There were zero residents affected by th deficient practice. | | |
| | each door and provisi rapid removal of occu locks; keying of all loc | ce shall be permitted on ons shall be made for the pants by: remote control of cks or keys carried by staff at h reliable means available | | | Residents residing on the Memory Care have the potential to be affected by this deficient practice in the event of an emergency. | Wing | |
| | SPECIAL NEEDS LO Where special locking | .6, 19.2.2.2.5.1, 19.2.2.2.6 CKING ARRANGEMENTS garrangements for the | | | III. The following system changes will implemented to assure continuing compliance with regulations: | II be | |
| | Clinical or Security Lo being met. In addition electrical locks that fa upon loss of power to protected by a superv | il safely so as to release the device; the building is ised automatic sprinkler d space is protected by a | | | The Memory Care Wing double doors we set to provide push to egress protection Signage was placed indicating push to edoors can be opened in 15 seconds. Countryside Alarms conducted an insper of the smoke detection system on 10/27 All smoke zone doors were determined provide release through activation of the | exit, ection 7/23. | |
| 4500ATORY 5 | 1 | at an attended location | | | smoke detection or sprinkler systems. | | (X6) DATE |

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.

PRINTED: 11/07/2023 FORM APPROVED DMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL AND PLAN OF CORRECTION IDENTIFICATION NO | IMBED: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 | | (X3) DATE SURVEY COMPLETED | | | |
|---|--|---|--|--|----------------------------|--|--|
| 47503 | 3 B. WING | G | | 10/ | 05/2023 | | |
| NAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD BENNINGTON, VT 05201 | | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENC PREFIX (EACH DEFICIENCY MUST BE PRECEDED B TAG REGULATORY OR LSC IDENTIFYING INFOR | Y FULL PRE | FIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | | |
| within the locked space); and both the spand detection systems are arranged to undoors 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 installed in accordance with 7.2.1.6.1 shapermitted on door assemblies serving low ordinary hazard contents in buildings prothroughout by an approved, supervised a fire detection system or an approved, supautomatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCARRANGEMENTS Access-Controlled Egress Door assemblinstalled in accordance with 7.2.1.6.2 shapermitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permit door assemblies in buildings protected the by an approved, supervised automatic fir detection system and an approved, super automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evide by: Based on a walkthrough of the premises 10/5/23 with the Facilities Director, surver activities determined that: 1) Memory care wing double doors do not push to egress protections; or signage "Fexit, doors can be opened in 15 seconds" | systems all be w and stected automatic pervised KING ies all be king n tted on stroughout re rvised enced s on y | K 222 | The unapproved bolts and hardware which limited egress to the corridor fire exits on double door in the small Activity Room with removed on 10/05/2023. IV. The facility's compliance will be monitored utilizing the following qualitiassurance system: The Memory Care Wing double doors we added to the weekly door/alarm check schedule for Preventative Maintenance. Inspection and Maintenance of the smoke detection system will be scheduled annual with a technically qualified person on file 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 Environments Services | the ere ty ere eally with | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | |
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| | 475033 | B. WING_ | | | 10 | 0/05/2023 |
| NAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD BENNINGTON, VT 05201 | | | |
| (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL | ID PREFI) TAG | ĸ | | | (X5) COMPLETION DATE |
| 2) Survey activities we this and other smoke unlock on sprinkler ar 3) The double door in North Corridor has unhardware which limit exits. Doors with Self-Closin CFR(s): NFPA 101 Doors with Self-Closin Doors in an exit passe or horizontal exit, smoor are an enclosure are seclosed position, unless device complying with closes all such doors compartment or entire * Local smoke detector smoke passing throug smoke detection syste * Automatic sprinkler structure to see the smoke on a walkthrough the smoke detection to 10/5/23 with the Facilia activities determined to provide of the smoke detection Fire Alarm System - In | ere unable to determine if zone doors are arranged to ad detection activations. small Activity room in the approved bolts and egress to the corridor fire and Devices ageway, stairway enclosure, oke barrier, or hazardous elf-closing and kept in the sheld open by a release a 7.2.1.8.2 that automatically throughout the smoke effacility upon activation of: effacility upon activation of: effacility upon activation of: effacility and ensystem; and ensystem, if installed; and ensystem, if installed; and ensystem, if installed; and ensystem, if installed; and ensystem ensystem ensystem ensystem ensystem ensystem ensystem ensystem ensystem. | K 2 | 2223 | I. The following actions were accomplished for the residents identifin the sample: There were zero residents identified in the sample. II. The following corrective actions we implemented to identify other resident 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 a semergency. III. The following system changes will implemented to assure continuing compliance with regulations: Countryside Alarms conducted an inspect of the smoke detection system on 10/27. All smoke zone doors were determined by provide release through activation of the smoke detection or sprinkler systems. IV. The facility's compliance will be monitored utilizing the following qualities assurance system: Inspection and Maintenance of the smok detection system will be scheduled annumith a technically qualified person on file the Division of Fire Safety. The system will be tested during the required prime prills scheduled for emergency preparedness. Results of the inspection/drills will be reviewed in the QAPI committee meeting account of the provide release through activation and the provide release through activation and the prime prills scheduled for emergency preparedness. | fied ne fill be ts e ected an l be ction /23. io ty e ally with uired | |
| | | | | months for further resolution if needed. | | |
| | ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page 2) Survey activities we this and other smoke unlock on sprinkler ar 3) The double door in North Corridor has un hardware which limit of exits. Doors with Self-Closin CFR(s): NFPA 101 Doors with Self-Closin Doors in an exit passa or horizontal exit, smo area enclosure are se closed position, unles device complying with closes all such doors compartment or entire * Required manual fire * Local smoke detector smoke passing throug smoke detection syste * Automatic sprinkler se * Loss of power. 18.2.2.2.7, 18.2.2.2.8, This REQUIREMENT by: Based on a walkthroug 10/5/23 with the Facilia activities determined to Smoke zone doors in determined to provide of the smoke detection | ROVIDER OR SUPPLIER IT MANOR CARE CTRS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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 * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Local smoke detection system; if installed; and * Local smoke detection system; for 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. Fire Alarm System - Installation | ROVIDER OR SUPPLIER TMANOR CARE CTRS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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 * Lucas 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. Fire Alarm System - Installation K 3 | TOWNER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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. Fire Alarm System - Installation K 341 | A BUILDING 01 A BUILDING 01 B. WIND STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD BENNINGTON, VT 05201 PROVIDER OR SUPPLIER T MANOR CARE CTRS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFING INFORMATION) 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. Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices CDORS 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 alams system; and *Local smoke detection system; and *Automatic sprinkler system, if installed; and *Local smoke detection system; and *Automatic sprinkler system, if installed; and *Local smoke detection system; and *Automatic sprinkler system, if installed; and *Local smoke detection or sprinkler systems. Fire Alam System an installation *K 241 **Smoke zone doors in corridors cannot be determined to provide release through activation of the smoke detection or sprinkler systems. Fire Alam System installation *K 241 **STREET ADDRESS, CITY, STATE, ZIP CODE **STREET ADDRESS, CITY, STATE, ZIP CODE **BENNINGTON, VT 05201 **PREPIX** **PREPIX** **PROVIDENCERCICION** **PRE | A BUILDING of A BUILDING of B. VINIO STREET ADDRESS. CITY, STATE. ZIP CODE 312 CRESCENT BLVD BENNINGTON, VT 08201 SUMMARY STATEMENT OF DEPICIENCIES GEACH DEPICIENCY WIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 boits and hardware which limit egress to the corridor fire exits. Doors with Self-Closing Devices CFR(s): NFPA 101 Dors with Self-Closing Devices CFR(s): NFPA 101 There were zero residents identified in the sample: II. The following actions were accomplished for the 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 in the event of an emergency. All residents have the potential to be affected by this deficient practice in the event of an emergency. III. 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 in the event of an emergency. 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 system on 10/27/23. All smoke zone doors were determined to provide release through activation of the smoke detection system on 10/27/23. All smoke zone doors were determined to provide release through activation of the smoke detection system on 10/27/23. All smoke zone doors were determined to provide rel |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KXK221

Facility ID: 475033

If continuation sheet Page 3 of 7

Completion Date: ____10/27/2023___

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--|----------|---|--|--------------------|
| | | 475033 | B. WNG | | <u> </u> | 10. | /05/2023 |
| NAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES | | | ID | 31 BI | REET ADDRESS, CITY, STATE, ZIP CODE 2 CRESCENT BLVD ENNINGTON, VT 05201 PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI) TAG | <u> </u> | (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | COMPLETION DATE |
| K 341 | Fire Alarm System - In A fire alarm system is components approved accordance with NFP and NFPA 72, National provide effective warm building. In areas not detection is installed a unit. In new occupance at notification appliance and supervising static | nstallation installed with systems and d for the purpose in A 70, National Electric Code, al Fire Alarm Code to hing of fire in any part of the continuously occupied, at each fire alarm control by, detection is also installed be circuit power extenders, on transmitting equipment, ing or other transmission or integrity. | K | 341 | K-341 – Fire Alarm System - Installati I. The following actions were accomplished for the residents ident in the sample: There were zero residents identified in the sample. II. The following corrective actions we implemented to identify other resident 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 emergency. | he ill be ts | |
| K 741 SS=D | by: Based on a walkthroid 10/5/23 with the Facilia activities determined in 1) No documentation time of survey to demitesting of the required no report by a Technic file with the Division of the county of the system has not occur. 2) Sensitivity testing of the system has not occur. Quarter 1 of 2021. Smoking Regulations CFR(s): NFPA 101. | was available on site at the onstrate maintenance and I smoke detection system; cally qualified person was on if Fire Safety. of the Smoke detection red throughout since | ĸ: | 741 | implemented to assure continuing compliance with regulations: Countryside Alarms conducted an inspect of the smoke detection system on 10/27 IV. The facility's compliance will be monitored utilizing the following qualessurance system: Inspection and Maintenance of the smodetection system will be scheduled ann with a technically qualified person on filthe Division of Fire Safety. Results of the inspection will be review the QAPI committee meeting x 4 month further resolution if needed. Completion Date: | ection 1/23. lity ke ually e with ed in s for | |

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|--|--|-----------------------------|--|--|--|
| | 475033 | B. WING | | 10/05/2023 | |
| NAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD BENNINGTON, VT 05201 | | |
| PREFIX (EACH DEFICIENCY | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETION | |
| (1) Smoking shall be pward, or compartment combustible gases, of and in any other haza area shall be posted with SMOKING or shall be international symbol for (2) In health care occur prohibited and signs at major entrances, second that prohibits smoking (3) Smoking by patient responsible shall be posted where the patient is used (5) Ashtrays of noncondesign shall be provided smoking is permitted. (6) Metal containers with devices into which asled be readily available to permitted. 18.7.4, 19.7.4 This REQUIREMENT by: Based on a walkthrout 10/5/23 with the Facility activities determined to 1) A smoking policy has smoking signs were rethe facility. Smoking propatient's use during 12) Staff smoking area to be policed with propagations. | the following provisions: prohibited in any room, at where flammable liquids, roxygen is used or stored redus location, and such with signs that read NO posted with the por no smoking. Upancies where smoking is are prominently placed at all pondary signs with language at shall not be required. Its classified as not prohibited. If 18.7.4(3) shall not apply under direct supervision. In the self-closing cover posted in all areas where with self-closing cover posted in all areas where smoking is used to be preceded by the premises on the self-closing cover posted in all areas where smoking is all areas where smoking is all areas where smoking is used to be preceded by the premises on the premises on the premises on the self-closing cover posted by the premises on the premises of the premise | K 741 | I. The following actions were accomplished for the residents id in the sample: There were zero residents identified sample. II. The following corrective action implemented to identify other residents who may be affected by the same practice: There were zero residents affected deficient practice. All residents have the potential to be by this deficient practice in the even emergency. Employee Smoking Policy was revier revised. Resident Smoking Policy was revier revised to address use during incless weather. III. The following system changes implemented to assure continuing compliance with regulations: Employees were educated on the reamployee Smoking Policy and the Fomoking Policy. "No Smoking" signs were placed at entrances to the facility. Proper extinguishing receptacles we more than 35' away from the Staff Employee smoking area was cleared debris. Receptacles in Huntington's smoking were moved further from the patio. | in the ins will be idents by the e affected it of an ewed and ewed and ment s will be desident the ere placed intrance. d of | |

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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 B WING 475033 10/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD CRESCENT MANOR CARE CTRS BENNINGTON, VT 05201 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) IV. The facility's compliance will be monitored utilizing the following quality Continued From page 5 K 741 assurance system: entrance. The Employee Smoking Area will be inspected daily x 2 weeks and weekly 3) Huntington's patients who smoke were thereafter to ensure the area remains clear of supervised, however receptacles should be debris and that the receptacles are at least moved further from the patio. 35' from the staff entrance. K 918 K 918 | Electrical Systems - Essential Electric Syste SS=B | CFR(s): NFPA 101 The Huntington's Smoking Area will be inspected daily x 2 weeks and weekly thereafter to ensure that the smoking Electrical Systems - Essential Electric System receptacles are moved further from the patio. Maintenance and Testing The generator or other alternate power source Results of the audits will be reviewed in the and associated equipment is capable of supplying QAPI committee meeting x 4 months for further resolution if needed. 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 Completion Date: capability for the life safety and critical branches. 11/15/23 Maintenance and testing of the generator and Responsibility: Director of Environmental transfer switches are performed in accordance Services with NFPA 110. Generator sets are inspected weekly, exercised K-918 Electrical Systems - Essential under load 30 minutes 12 times a year in 20-40 **Electric System Maintenance and Testing** day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test I. The following actions were under load conditions include a complete accomplished for the residents identified in the sample: simulated cold start and automatic or manual transfer of all EES loads, and are conducted by There were zero residents identified in the competent personnel. Maintenance and testing of sample. stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder II. The following corrective actions will be circuit breakers are inspected annually, and a implemented to identify other residents who may be affected by the same program for periodically exercising the practice: components is established according to manufacturer requirements. Written records of There were zero residents affected by the maintenance and testing are maintained and deficient practice. 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

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| | 475033 | B. WING | | <u> </u> | 10/ | 05/2023 |
| Continued From page source is a design coinstallations. 6.4.4, 6.5.4, 6.6.4 (NF 111, 700.10 (NFPA 70 | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 2 6 Insideration for new FPA 99), NFPA 110, NFPA | B. WING | | CRESCENT BLVD NNINGTON, VT 05201 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) III. The following system changes will be implemented to assure continuing compliance with regulations: Generator Set Emergency Lighting was installed. | | 05/2023 (X5) COMPLETION DATE |
| 10/5/23 with the Facil activities determined. No Generator Set Emin the event of power/ | | | | IV. The facility's compliance will be monitored utilizing the following quassurance system: The Generator Set Emergency Lighting added to the weekly generator prevent maintenance schedule. Results of the preventative maintenance checks will be reviewed in the QAPI committee meeting x 4 months for furth resolution if needed. Completion Date: 11/15/23 Responsibility: Director of Environ Services K-353 Sprinkler System — Maintenance and Testing I. The following actions were accomplished for the residents identing the sample: There were zero residents identified in sample. II. The following corrective actions implemented to identify other resid who may be affected by the same practice: There were zero residents affected by deficient practice. | g was ative ce mer mental nce ntified the will be ents | |

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE | | PROVIDER # | MULTIPLE CONSTRUCTION | DATE SURVEY | | | | | |
|--|---|-----------------------------|---|--------------|--|--|--|--|--|
| NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM | | | A. BUILDING: 01 | COMPLETE: | | | | | |
| FOR SNFs AND NF | | 475033 | B. WING | 10/5/2023 | | | | | |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STAT | TE, ZIP CODE | | | | | | |
| THE OF THE VIDER ON BOTTELER | | 312 CRESCENT BLVD | | | | | | | |
| CRESCENT MANOR CARE CTRS | | BENNINGTON, VT | | | | | | | |
| ID | | | | | | | | | |
| PREFIX | ALL ALL DIVISITIES AND AN OF PRESIDENCE AND AND AN OF PRESIDENCE AND | | | | | | | | |
| 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 ar | e inspected, tested, and ma | aintained in accordance with NFPA | | | | | | |
| | | _ | Maintaining of Water-based Fire Protection Systems. Records | | | | | | |
| | of system design, maintenance, inspection and | d 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 covera | | r partial automatic aprinklar ayatam | | | | | | |
| | 9.7.5, 9.7.7, 9.7.8, and NFPA 25 | ige for any non-required of | partial automatic sprinkler system. | | | | | | |
| | This REQUIREMENT is not met as evidence | ad by: | | | | | | | |
| | Based on a walkthrough of the premises on 10 | • | Director survey activities determined | | | | | | |
| | that: | "3/23 with the Pacifiles L | offector, survey activities determined | | | | | | |
| | tilat. | | | | | | | | |
| | Sprinkler System A TQP sprinkler system repeat the entrance. | ort of 2/14/2023 reports th | at there are "outdated dry sidewalls" | | | | | | |
| | at the chitanee. | | All residents have the potential to by this deficient practice in the emergency. | | | | | | |
| | | | III. The following system char implemented to assure contin compliance with regulations: | | | | | | |
| | | | The "outdated dry sidewalls" at noted on the sprinkler system re 02/14/2023 were replaced. | | | | | | |
| | will be ing quality | | | | | | | | |
| | | | Results of the sprinkler inspection be reviewed in the QAPI comming x 4 months for further resolution | ttee meeting | | | | | |
| | | | Completion Date:11/15/23 | | | | | | |
| | Tag K 353 POC accepted on 11/ M. Steele/T. Wehmeyer | 14/23 by | Responsibility: Director of Er Services | nvironmental | | | | | |

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

The above isolated deficiencies pose no actual harm to the residents