



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

Division of Licensing and Protection  
103 South Main Street  
Waterbury, VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

August 18, 2015

Wendy Beatty, Administrator  
Crescent Manor Care Ctrs  
312 Crescent Blvd  
Bennington, VT 05201-0170

Provider #: 475033

Dear Ms. Beatty:

The Division of Licensing and Protection conducted an onsite complaint investigation on **August 11, 2015**. The purpose of the investigation was to determine if your facility was in compliance with Federal participation requirements of the Medicare/Medicaid Program. The investigation was completed on **August 11, 2015** and there were no regulatory violations related to the complaint allegations.

Sincerely,

A handwritten signature in cursive script, appearing to read "Pamela M. Cota".

Pamela M. Cota, RN  
Licensing Chief

Enclosure



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/11/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CRESCENT MANOR CARE CTRS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>312 CRESCENT BLVD</b> <b>BENNINGTON, VT 05201</b>		
(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
F 000	INITIAL COMMENTS  An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 8/11/15. As a result of the review there were no regulatory violations.	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (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.