

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

January 9, 2019

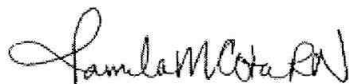
Mr. Mike Rivers, Administrator
Crescent Manor Care Ctrs
312 Crescent Blvd
Bennington, VT 05201-0170

Dear Mr. Rivers:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 16, 2018**. Please post this document in a prominent place in your facility.

We may 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,



Pamela M. Cota, RN
Licensing Chief



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

PRINTED: 11/30/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2018
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	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)
F 000	INITIAL COMMENTS An unannounced on-site investigation of a facility self-report and a complaint was conducted on 11/13/18 through 11/16/18 by the Division of Licensing and Protection. The following regulatory violations were identified:	F 000	<div style="border: 1px solid black; padding: 5px;"> <p>The following constitutes the Facility's response to the findings Of the Department of Licensing and Does not constitute an admission of Guilt or agreement of the facts alleged or conclusions set for the summary statement of deficiencies</p> </div>
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (I) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or	F 622	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Hite* TITLE *Administrator* (X6) DATE *12/4/18*

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.

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

PRINTED: 11/30/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2018
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	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 622	<p>Continued From page 1</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation.</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c)(1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p>	F 622	

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

PRINTED: 11/30/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/16/2018
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	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 622	Continued From page 2 (III) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that when a transfer and/or discharge of a resident was necessary, the physician's documentation in the medical record specified the needs of the resident that could not be met, attempts to meet the needs, and the service available at the receiving facility for 2 of 3 applicable residents in the sample (Resident #1 and Resident #2). Findings include: Per record review Resident #1 was transferred to the hospital on 10/4/18 for a medical and psychiatric evaluation and Resident # 2 was transferred to the hospital on 9/19/18 after a fall. For each of these residents', there was no evidence in the medical record that the physician documented the specific needs that the facility could not meet, the facility efforts to meet those needs, and the specific services the receiving facility would provide to meet the needs of the residents' which could not be met at the current facility. Per interview on 11/14/18 at 9:38 AM with	F 622	P622 1. Resident #1 no longer resident of facility. 2. All residents that have the potential to be effective by this deficient practice have been audited, and no others identified 3. DON educate all providers on the documentation requirement of transfer/discharge process 4. DON will audit residents' transfers for accuracy daily x1 week through 12/10/18 Then weekly times 4 weeks Then Monthly times 3 months. Results of these audits will be reported by DON at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director. Date of Compliance: 12/12/2018 <i>12/21/18</i>		

FLSA POC accepted 11/8/19 David.../PML

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

PRINTED: 11/30/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2018
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	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 622	Continued From page 3 the Director of Nursing (DNS), s/he confirmed that the physician did not document this information in the residents' medical record.	F 622		
F 623 SS=E	<p>Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)</p> <p>§483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-</p> <p>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to</p>	F 623	<p>F 623</p> <ol style="list-style-type: none"> 1. Resident #1 no longer a resident of facility, #2, affected by the deficient practice, all records immediately updated as needed 2. All residents that have the potential to be effective by this deficient practice have been audited, and no others identified. 3. NHA re-educated Social Service coordinator on regulation of importance of accurately notifying representatives/ombudsman on transfer/discharge 4. Administrator will audit residents' transfers for accuracy daily x1 week through 12/10/18 Then weekly times 4 weeks Then Monthly times 3 months. <p>Results of these audits will be reported by the Administrator at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director.</p> <p>Date of Compliance 12/12/18 <i>12/18/18</i></p>	

F623 POC accepted 11/8/19 DNS/Debra Pals/Pme

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

PRINTED: 11/30/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/16/2018
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	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 623	<p>Continued From page 4</p> <p>allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <ul style="list-style-type: none"> (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and 	F 623		

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

PRINTED: 11/30/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/16/2018
NAME OF PROVIDER OR SUPPLIER CRESCENT MAJOR CARE CTRS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 623	<p>Continued From page 5</p> <p>advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify the resident and/or resident's representative in writing of a transfer/discharge; and send a copy of the notice to the Ombudsman (public official appointed to investigate complaints people make against government and/or public organizations) for 2 of 3 applicable residents in the sample (Resident #1 and Resident #2). Also, the notice fails to meet requirement regarding the contents of the notice. Findings include:</p> <p>Per record review Resident #1 was transferred to the hospital on 10/4/18 for a medical and psychiatric evaluation. Resident #2 was transferred to the hospital on 9/19/18 after a fall, and readmitted to the facility on 9/22/18. Upon</p>	F 623			

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

PRINTED: 11/30/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2018
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	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 623	Continued From page 6 further record review, on 10/26/18, 23 days after the resident was transferred and/or discharged to the hospital, a transfer/discharge notice was sent to Resident #1's representative. For Resident #2, there was no evidence in the medical record that the transfer/discharge notice was sent in writing to the resident and/or resident's representative; and a copy of the notice was sent to the Ombudsman. Per interview on 11/14/18 at 12:29 PM with the social worker, s/he confirmed that a written notice was not given to Resident #1's representative at the time of discharge/transfer and that this notice was not sent to the Ombudsman. S/he also confirmed that for Resident #2 there was no written transfer/discharge notice given to the resident and/or resident's representative; and that the Ombudsman was not notified of the resident's transfer/discharge. The contents of the notice do not contain all required elements per the federal CMS requirements listed in this regulation. Also, State requirements regarding the notice are not met (see F9999).	F 623	
F 626 SS=D	Permitting Residents to Return to Facility. CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following: (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous	F 626	

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

PRINTED: 11/30/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2018
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	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 626	<p>Continued From page 7</p> <p>room if available or immediately upon the first availability of a bed in a semi-private room if the resident-</p> <p>(A) Requires the services provided by the facility; and</p> <p>(B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.</p> <p>(ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.</p> <p>§483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to readmit one resident (Resident #1) who was transferred with an expectation of returning to the facility, and then was denied readmission to the facility. Findings include:</p> <p>Per record review Resident #1 was transferred to the hospital on 10/4/18 for a medical and psychiatric evaluation. Per review of a case management note from the hospital dated 10/15/18, it read the facility, "will come tomorrow to screen patient and give final decision as to if</p>	F 626	<p>F 626</p> <ol style="list-style-type: none"> 1. Resident # 1 no longer a resident of this facility. 2. All residents that have the potential to be effective by this deficient practice have been audited, and no others identified. 3. Re-admission Policy developed and all nursing staff and social worker educated on the policy. 4. DON will audit residents' readmitted for accuracy daily x1 week through 12/10/18 <p>Then weekly times 4 weeks</p> <p>Then Monthly times 3 months.</p> <p>Results of these audits will be reported by the Administrator at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director.</p> <p>Date of Compliance 12/12/18 12/21/18</p> <p><i>F626 POC accepted 1/8/19 Dmdcauckepn/pmc</i></p>

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

PRINTED: 11/30/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2018
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	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 626	Continued From page 8 they can accept ...back in their facility". A case management note from 10/16/18 stated that a staff member from the facility visited the resident on this date and the "Facility declined to admit at this time". Per review of a social work progress note dated 10/27/18, it read, "Patient to be transferred (to another facility out-of-state and farther away from family/community) on 10/29/18". Per interview on 11/14/18 at 12:50 PM with a hospital social worker, s/he stated that Resident #1 was ready to be discharged on 10/5/18 and that the facility had refused to take the resident back at that time. S/he stated that on 10/16/18, a staff member from the facility had come to the hospital to assess the resident and that the facility had declined to take the resident back. S/he confirmed that the resident was discharged from the hospital on 10/29/18.	F 626	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656	

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

PRINTED: 11/30/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2018
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	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 656	<p>Continued From page 9</p> <p>provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to implement the care plan for 1 of 3 resident's in the applicable sample (Resident #1). Findings include:</p> <p>Per record review Resident #1's care plan read, "Supervision with ambulation throughout the unit"; "independent ambulation; however, has supervision and 1 assist due to behaviors". Per interview on 11/14/18 at 3:03 PM with the DNS, s/he stated that to supervise a resident meant that staff had eyes on the resident and/or were with the resident at all times.</p> <p>On 10/4/18 at approximately 11:50 PM, Resident</p>	F 656	<p>F 656</p> <ol style="list-style-type: none"> 1. Resident #1 no longer a resident of facility and resident #2, affected by the deficient practice, all records immediately updated as needed 2. All residents that have the potential to be effective by this deficient practice have been audited, and no others identified. Manager/designee completed full audit of care plans 12/3/2018 3. Educator re-educated all nursing staff on care plans location, updated and following of care plans 4. Manager/designee will audit all revised care plans daily through 12/10/18 <p>Then weekly times 4 weeks</p> <p>Then Monthly times 3 months.</p> <p>Results of these audits will be reported by the Administrator at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director.</p> <p>Date of Compliance 12/12/18 12/12/18</p> <p><i>F656 POC accepted 1/5/19 DW/dec/ker/PM/PAW</i></p>

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

PRINTED: 11/30/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2018	
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	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 656	Continued From page 10 #1 was involved in a resident to resident altercation with Resident #2. Per interview with Staff Nurse #2 on 11/14/18 at 7:43 AM, s/he stated that on 10/4/18 prior to the altercation, s/he did see Resident #1 walk down the hall; however, s/he did not see where Resident #1 went. S/he stated that s/he was helping another resident at the time and had asked the LNA to go look for Resident #1. Per interview on 11/14/18 at 9:56 AM with a LNA, s/he stated that on 10/4/18 prior to the altercation, s/he was preparing a snack for another resident and once s/he was finished with what s/he was doing, s/he went to look for Resident #1. S/he confirmed that s/he was busy and not supervising Resident #1 while Resident #1 was walking in the hall.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide adequate supervision for 1 of 3 residents in the applicable sample (Resident #1). Findings include: Per review of a nursing progress note from 9/23/18 for Resident #1, the resident "continues with close supervision of staff ...behaviors at this time are...more physical and stronger towards	F 689		

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

PRINTED: 11/30/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2018
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	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 689	Continued From page 11 staff...not able to control strength and...is becoming more aggressive and more persistent". On 10/4/18 a nursing progress note read, "During overnight shift report with evening shift nurse at 10:25 PM witnessed resident throw a punch toward pharmacy delivery staff at nurse's station. Resident redirected". On 10/4/18 at approximately 11:50 PM the nurse witnessed Resident #1 walk down the hall past the nurse's station. Resident #1 was found in Resident #2's room with a pillow over Resident #2's head. Per interview with Staff Nurse #2 on 11/14/18 at 7:43 AM, s/he stated that on 10/4/18 prior to the altercation, s/he did see Resident #1 walk down the hall; however, s/he did not see where Resident #1 went. S/he stated that s/he was helping another resident at the time and had asked the LNA to go look for Resident #1. S/he confirmed that prior to Resident #1 being found in Resident #2's room, Resident #1 was unsupervised. Per interview on 11/14/18 at 9:56 AM with a LNA, s/he stated that on 10/4/18 prior to the altercation, s/he was preparing a snack for another resident and once s/he was finished with what s/he was doing, s/he went to look for Resident #1. S/he confirmed that s/he was busy and not supervising Resident #1 while Resident #1 was walking in the hall.	F 689	F 689 1. Resident #1 no longer a resident of facility and resident #2, affected by the deficient practice, all records immediately updated as needed 2. All residents that have the potential to be effective by this deficient practice have been audited, and no others identified. Manager/designee completed full audit of care plans 12/3/2018 3. Educator re-educated all nursing staff on care plans location, updated and following of care plans 4. Manager/designee will audit all revised care plans daily through 12/10/18 Then weekly times 4 weeks Then Monthly times 3 months. Results of these audits will be reported by the Administrator at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director. Date of Compliance 12/12/18 <i>12/21/18</i>	
F9999	FINAL OBSERVATIONS The following two (2) violations of Vermont Licensing and Operating Rules for Nursing Homes were identified in relation to the notice of transfer/discharge being used by the facility. 3.14 Transfer and Discharge #1) 3.14 (e) Contents of the notice. The written	F9999	F089 POC accepted 1/8/19 DW/DeWachter/PMC	

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

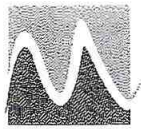
PRINTED: 11/30/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2018
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	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
F9999	<p>Continued From page 12</p> <p>notice specified in this subsection shall be on a form provided by the licensing agency or one that is substantially similar and must include the following:</p> <p>(1) the reason for transfer or discharge;</p> <p>(2) the effective date of transfer or discharge;</p> <p>(3) the location to which the resident is being transferred or discharged;</p> <p>(4) a statement in large print or large point type that the resident has the right to appeal the facility's decision to transfer or discharge to the State, with the appropriate information regarding how to do so as set forth in 3.14 (h) below;</p> <p>(5) the name, address and telephone number of the State Long Term Care Ombudsman;</p> <p>(6) a statement that the resident may remain in place pending the appeal;</p> <p>(7) for nursing facility residents with developmental disabilities, the mailing address and telephone number of the Developmental Disability Law Project and that of the Vermont Department of Developmental and Mental Health Services, Division of Developmental Services; and/or</p> <p>(8) for nursing facility residents who are mentally ill, the mailing address and telephone number of Vermont Protection and Advocacy, Inc.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Per review of the facility notice of intent to Transfer/Discharge, the notice does not contain a statement that the resident may remain in place pending appeal and does not contain the mailing address and telephone number of the Vermont Protection and Advocacy, Inc.</p>	F9999	<p>F9999</p> <ol style="list-style-type: none"> 1. Notice updated to content relevant information: statement that the resident may remain in place pending appeal and the address and telephone number of the Vermont Protection and advocacy, inc and the time frames of the appeal process 2. All forms updated and available to be sent immediately with resident's if needed. 3. Educator re-educated all nursing staff about the revised forms 4. Social Worker audit any transfer/discharges daily x 1 week 12/10/18 Then weekly times 4 weeks Then Monthly times 3 months. <p>Results of these audits will be reported by the Administrator at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director.</p> <p>Date of Compliance 12/12/18 12/11/18 <i>MC</i></p> <p><i>F9999 POC accepted 1/2/19 PW/Deanna/BRW/PWW</i></p>

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

PRINTED: 11/30/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/16/2018
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	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	
F9999	Continued From page 13 #2) 3.14 (h) Appeal process. A resident has the right to appeal the facility's decision to transfer or discharge. The process for appeal is as follows: (1) To appeal the decision the transfer or discharge, the resident must notify the administrator of the facility or the director of the licensing agency. Upon receipt of an appeal, the administrator must immediately notify the director of the licensing agency. (2) The request to appeal the decision may be oral or written and must be made within 10 business days of the receipt of the notice by the resident. This REQUIREMENT is NOT MET as evidenced by: Per review of the facility notice of intent to Transfer/Discharge, the notice does not contain the time frames of the appeal process.	F9999			



CRESCENT MANOR
REHABILITATION
A NIMA HEALTHCARE FACILITY

312 Crescent Boulevard • Bennington VT, 05201 • Tel: 802.447.1501

NOTICE OF INTENT TO TRANSFER/DISCHARGE

Date: _____

Resident: _____ Representative: _____

The purpose of this letter is to inform you that this facility seeks to Transfer/Discharge you to _____ on ___/___/_____. The reason for this transfer/discharge is: _____

You have the right to appeal the decision of transfer. You have the right to remain in your room until there is a final decision on your appeal. To appeal, you must complete the following steps:

*** You or your legal representative must inform the Facility Administrator, Mike Rivers that you wish to appeal this transfer notice. You can make this request verbally or in writing. You can contact the Director of the licensing agency at:**

**Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, Vermont 05671-2060
(802) 241-0480
surveyandcertification@vermont.gov**

- * You must request the appeal within 10 business days from the date you receive this notice.**
- * At the time you request the appeal, you or your legal representative must provide material or information to the Director explaining why you disagree with the proposed transfer. You may present this material or information verbally if you are unable to do it in writing. At your request, the licensing agency will send you any material or information it receives from the home explaining why they want to transfer you.**
- * The Director of licensing agency will make a decision within eight business days of your request to appeal the transfer.**

*** If you do not understand this letter or you would like help requesting an appeal, you can contact the Long Term Ombudsman, Vermont Protection and Advocacy or the Vermont Senior Citizen's Law Project. The Long Term Care Ombudsman for this area is Jane Monroe, who can be reached at:**

**Vermont Ombudsman Project
57 North Main Street, Suite 2
Rutland, Vermont 05701
(802) 855- 2411
j.munroe@vtlegalaid.org**

Disability Rights Vermont
*** Formerly Vermont Protection & Advocacy**
141 Main Street, Suite # 7
Montpelier, Vermont 05602
(800) 834-7890 (Toll Free)
(802) 229-1355 (Voice)
(802) 229-2603 (TTY)
(802) 229-1359 (Fax)
Email: info@disabilityRightsVT.org
On the Web: www.disabilityrightsvt.org

If the resident has DD or Mental Illness include the following in addition to above: You may also contact:

Vermont Dept. of Disability, Aging and Independent Living
Divisions of Disability and Aging Service
Waterbury, Vermont 05671-2030
(802) 241-2401

Vermont Dept. of Mental Health
280 State Drive NOB 2North
Waterbury, Vermont 05671-2010
(802) 241-0090

email varies by case worker, best contact is phone number

If you want the facility to hold the bed for: _____ during his/her hospitalization
please sign below:

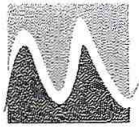
Agree Disagree

_____ (Signature) _____ (Date)

Should you have any questions or would like assistance in filing an appeal for a fair hearing, feel free to contact me.

312 Crescent Blvd
Bennington, Vermont 05201
(802)447-1501

_____ Social Worker/Designee



**CRESCENT MANOR
REHABILITATION**
A MIMA HEALTHCARE FACILITY

312 Crescent Boulevard • Bennington VT, 05201 • Tel: 802.447.1501

REQUEST FOR A FAIR HEARING
(Within 10 Business Days)

Date: _____

Notice to:
(Name and address of resident)

Copies to:
(Name and address of representative)

Social Security number of resident: _____

I wish to appeal the plan of _____
(Name of Nursing Facility)

To transfer/discharge me.

Attached is a copy of the transfer/discharge notice provided to me by the nursing facility and received on _____
(Date of Receipt)

Date

Signature of Resident or Representative

Mail this form to:

Division of Licensing and Protection
HC 2 South – 280 State Drive
Waterbury, Vermont 05671-2060
(802) 241-0480
Email: AHS.DAILDLPIntake@vermont.gov

Give a copy of this form to the nursing facility contact person.

You will be notified by mail of the date, time, place and hearing officer who will hear your appeal. Failure to appear at the hearing without good cause may result in the dismissal of the appeal. If you are disabled, you have the right to request that the division accommodate your disability to ensure your access to the fair hearing.