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

May 20, 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 **April 17, 2019**. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475033	A. BUILDING _____ B. WING _____	C 04/17/2019

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
F 000	INITIAL COMMENTS An announced on-site investigation of two (2) facility reported incidents in conjunction with one (1) complaint investigation was conducted by the Division of Licensing and Protection on 4/17/2019. The following regulatory deficiencies were identified.	F 000	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	
F 608 SS=D	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as	F 608	F608 1. Employee involved in possible suspicion of a crime is no longer employed by facility 2. No other employee's identified as being suspicion of a crime at this time 3. Administrator to re-educated DON on importance of reporting any suspicion of a crime to state agencies 4. DON will audit 100 % of subsequent reportable to assure that required agencies have been notified as required Audits as needed next 3 months Results of these audits will be reported by the Manager or Designee at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director. Date of Compliance 5/8/2019	

F608 POC accepted 5/17/19 SFreemanRN/PMC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mike Rives	Administrator	5/2/19

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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F 608	Continued From page 1 defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to implement policy and procedure for reporting a suspicion of a crime to the State Agency. Findings include: Per interview with the Director of Nurses (DNS) on 4/17/19, there was a report of concerns regarding a Licensed Practical Nurse (LPN) was improperly administering narcotics to a resident in the facility. The concern was brought to the attention of the staff educator on 9/14/18 that the LPN was administering a narcotic (Norco) too frequently to one of the residents in the facility. The DNS was made aware of the concern on 9/17/18 and on that day the concern was made known to him/her, there was a detective from the Office of Professional Regulations that came to the facility to discuss an anonymous complaint regarding the possible diversion of medications. The DNS stated that the LPN was terminated because of poor nursing practices. The DNS further stated that the facility did not report to other entities, including Division of Licensing and Protection and Adult Protective Services as well as notification to the local police.	F 608		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609		

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

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F 609	Continued From page 2	F 609	F609	

source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on resident and staff interviews and record review the facility failed to report an incident of alleged abuse for one (1) of four (4) residents, (Resident #1). Findings include:

Per nursing progress notes on 3/23/2019 at 12:15 PM, Resident # 1 was sitting in the television room with another resident. Two (2) nurses heard a noise from the television room causing them to respond. At that time Resident # 1 stated that he was "just punched in the face" by the other resident in the room.

During an interview with Resident #1 on 4/17/19 at 10:30 AM s/he stated that s/he "had been punched in the face by that guy down the hall and

1. Resident #1 affected by the deficient practice, the patient was assessed and provider notified by registered nurse at time of incident no injury, no pain or evidence of any physical contact identified at the time of incident

2. All residents that have the potential to be effective by this deficient practice of failure to report an incident of alleged abuse reviewed no others identified all incidents have been reported

3. Administrator to re-educate DON on importance of reporting any incident of alleged abuse to state agencies as required.

4. DON will audit 100 % of subsequent reportables to assure that required agencies have been notified as required

Audits as needed next 3 months

Results of these audits will be reported by the Manager or Designee at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director.

Date of Compliance 5/8/2019

F609 POC accepted 5/17/19 SFreemanRN/PTMC

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F 609	Continued From page 3 it hurt like hell". Per interview with the Director of Nursing (DON) on 4/17/19 at 10:15 AM, s/he confirmed that Resident #1 had reported being punched in the face on 3/23/19. The DON also confirmed that the incident was not reported to the licensing agency per regulatory requirements.	F 609		
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 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (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. (iv)In consultation with the resident and the	F 656		

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F 656	Continued From page 4	F 656		

resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(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.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to develop an at risk for elopement care plan for one (1) of four (4) residents, (Resident #2). Findings include:

On 1/21/19 Resident #2 left the facility by jumping out the window in his/her room, without authorization or notification to the facility.

Per record review a Behavior Note from 1/21/19 at 1:26 AM, stated that the nurse working on the unit received a phone call from the evening nurse stating that s/he saw a person walking down the road and the nurse should go check Resident #2's room to make sure s/he was in the room. The Nurse on duty went to Resident #2's room and the resident was not there, "the window was open, had no screen in it, and there were footprints in the snow from where he jumped."

On 12/7/18 an At Risk for Elopement Assessment was completed and Resident #2 was found to be "at risk to wander." An at risk for elopement care plan was not implemented at that time. The initial

F 656

1. Resident #2 affected by the deficient practice "at risk to wander" assessment completed and updated as identified

2. All residents that have the potential to be effective by this deficient practice have been audited 18 identified for "at risk to wander" and care plans updated as needed

3. Educator will re-educate all nursing staff on importance of completing wandering care plan when patient found 'at risk to wander"

4. Manager or designee will audit all new admissions, all quarterly assessments for wandering, elopement, documentation daily x1 week through 5/8/2019

Then weekly times 4 weeks 6/5/2019

Then Monthly times 3 months.

Results of these audits will be reported by the DON at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director.

Date of Compliance 5/8/2019

F656 POC accepted 5/17/19 sFreemanRN/PMC

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F 656	Continued From page 5 At Risk for Elopement care plan was not implemented until 1/28/19, seven (7) days after Resident #2 eloped from the facility. During an interview with the Registered Nurse (RN), Huntington's Coordinator on 4/17/19 at 1 PM, it was confirmed that on 1/21/19 Resident #2 had left the facility through his/her window without authorization or notification. The RN also confirmed that there was no evidence in the record that an elopement care plan was completed at the time of the 12/7/18 Elopement Risk Assessment, and that it was implemented seven (7) days after the actual incident.	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 resident and staff interviews and record review the facility failed to provide adequate supervision to maintain safety for one (1) resident, (Resident #2). Findings include: On 1/21/19 Resident #2 left the facility by jumping out the window of his/her room, at night, dressed in a tee shirt, jeans, and shoes, without authorization or notification that he was leaving. Per record review, a Behavior Note from 1/21/19	F 689		

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F 689	Continued From page 6	F 689	F689	

at 1:26 AM states that "two (2) aides [Licensed Nursing Assistants] came to me [the writer] saying that [Resident #2] was messing with [his/her] window. Went and got supervisor [Registered Nurse] to come with me to check [his/her] room out. Two out of three windows were shut except one all windows had screens in them."

The Nurse later received a phone call from the Nurse from the previous shift reporting that s/he had seen a person walking down the street and that the Nurse on duty should go check on the resident. The resident was found to not be in his/her room. The window was open with no screen in it and there were footprints in the snow where he jumped.

An at Risk for Elopement Assessment that was completed on 12/7/18 indicating that Resident #2 was at risk for wandering. Although Resident #2 was assessed to be at risk for wandering and found "messing with his windows" on the night of the incident, there was no evidence of any interventions put in place to prevent elopement such as, the need to provide increased supervision.

During an interview with the Huntington's Coordinator on 4/17/19 at 1:00 PM, confirmation was made that there was no evidence in the record that interventions such as increased supervision were put in place. The resident was picked up by a staff member near the Police station, approximately 1 mile from the facility.

On 4/17/19 at approximately 12:30 PM an interview with the Director of Nursing (DON), confirmed that the resident had left the facility at

1. Resident #2 affected by the deficient practice was immediately assessed on 1/21/19, no injury identified at that time. Placed on close supervision/ room checks x 1 week

2. All residents that have the potential to be effective by this deficient practice have been audited 0 identified for adequate supervision to maintain safety

3. Educator will re-educate all nursing staff on importance of providing adequate supervision to residents as needed

4. Manager or designee will audit all new admissions, all quarterly assessments for need of increase supervision, documentation daily x1 week through 5/8/2019

Then weekly times 4 weeks through 6/5/2019

Then Monthly times 3 months.

Results of these audits will be reported by the DON at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director.

Date of Compliance 5/8/2019

F689 POC accepted 5/17/19 SFreemanRN/Pane

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F 689	Continued From page 7 night, unsupervised, through his window.	F 689		