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 31, 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 **May 8, 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 _____	05/08/2019

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

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E 000	Initial Comments An unannounced, onsite emergency preparedness survey was conducted during the annual recertification survey by the Division of Licensing and Protection between 5/6 - 5/8/19. The following regulatory violations were identified related to emergency preparedness:	E 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	
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records.	E 023	E023 1. No Patients were affected by this deficient practice. 2. All patients have the potential to be affected by this deficient practice. Policy was updated to identify that 95 % of medical record is electronic and the other 5% is part of a paper chart. During an emergency, paper chart will be sent with the patient if evacuation is necessary, or locked in medication room or other secured areas. 3. The DON will re-educate all staff on the revisions of the policy and how to implement in case of emergency. 4. DON will audit education of staff weekly x4 and for new staff after each orientation for 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 6/2/2019 E023 POC accepted 5/30/19 LLoveren/PMC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mike Rivers — TITLE: Administrator — (X6) DATE: 5/28/19

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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E 023	Continued From page 1 *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to maintain a system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. Findings include: Per interview regarding emergency preparedness, there is no evidence that the facility has a system to preserve patient information as required. Per interview on 5/8/19 at 11:22 AM, the Director Of Nurses (DON) and the Administrator confirmed that the facility is not in compliance with this regulation.	E 023		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually.	E 037		

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E 037	Continued From page 2 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness	E 037	E037 1. No Patients were affected by this deficient practice. 2. All patients have the potential to be affected by this deficient practice. NHA and Director of Maintenance to provide a training program for all staff. 3. The NHA and Director of Maintenance will re-educate all staff on the emergency preparedness policies, procedures and training 4. The NHA and Director of Maintenance will audit education of staff weekly x4 and for new staff after each orientation for 3 months Results of these audits will be reported by the NHA at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director. Date of Compliance 6/2/2019 E037 POC accepted 5/30/19 LLovell RN/PMR	

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E 037	Continued From page 3 policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented	E 037		

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E 037	Continued From page 4 and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by:	E 037		

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E 037	Continued From page 5 Based on staff interview and record review, the facility failed to provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. Findings include: Per interview regarding emergency preparedness, there is no evidence that the facility provided the required training for emergency preparedness. Per interview on 5/8/19 at 11:22 AM, the Director Of Nurses (DON) and the Administrator confirmed that the facility is not in compliance with this regulation.	E 037		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is	E 039		

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E 039	Continued From page 6 community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop	E 039	E039 1. No Patients were affected by this deficient practice. 2. All patients have the potential to be affected by this deficient practice. NHA and Director of Maintenance to provide testing for all staff. 3. The NHA and Director of Maintenance will re-educate all staff on the emergency preparedness policies, procedures and testing 4. The NHA and Director of Maintenance will audit education of staff weekly x4 and for new staff after each orientation for 3 months Results of these audits will be reported by the NHA at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director. Date of Compliance 6/2/2019 E039 POC accepted 5/30/19 LLovell RN/PMR	

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E 039	Continued From page 7 exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to conduct exercises to test the emergency plan (EP) at least annually. Findings include: During interview regarding emergency preparedness, there is no evidence that the facility conducted exercises to test the EP at least annually. Per interview on 5/8/19 at 11:22 AM, the Director Of Nurses (DON) and the Administrator confirmed that the facility is not in compliance with this regulation	E 039		
F 000	INITIAL COMMENTS An unannounced onsite recertification survey was conducted by the Division of Licensing and Protection between 5/6 - 5/8/19. The following regulatory findings were identified:	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584		

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F 584	Continued From page 8 possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview, the facility failed to ensure a safe, clean, comfortable and homelike environment for residents. Per facility tour with the Environmental Director and the Facility Administrator on 5/8/19 at 10:39 AM, there were multiple areas in need of necessary housekeeping and maintenance services. Rooms (#4, 8, 9, 10, 14 & 16) had	F 584	F584 1. Patients in rooms # 4, 8, 9, 10, 13, 14, 16, 33, 35 were affected by this deficient practice. All of these rooms were cleaned and repaired. 2. All patients have the potential to be affected by this deficient practice. All rooms were audited to identify items that need cleaning and repair. All cleaning and repair was completed. 3. NHA re-educated Director of Housekeeping on cleaning schedules and processes to assure that all areas of the facility are clean and on the process for reporting areas that require housekeeping. 4. The NHA will audit the facility to assure that all areas are clean and there are no repairs needed. Audits will be completed 5 times a week x 2 weeks then weekly x 3 months. NHA will report results during the monthly QI meeting. The QI is attended by the NHA, DON and Medical Director. Date of Compliance 6/2/2019 F584 POC accepted 5/30/19 LLovell RN/PMC	

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F 584	Continued From page 9 overhead lighting that had dead insects inside their covers, room #9 also had a cobweb hanging from the overhead light. Room #13 had overhead lights with either no light bulbs or bulbs that were missing, so there was no overhead lighting available. The shared bathroom between rooms #33 and #35 needed cosmetic repairs. The tile surrounding the toilet was badly stained and appeared to be dirty. The above findings were confirmed by the Environmental Director and the Facility Administrator on 5/8/19 at approximately 11:00 AM. The Environmental Director confirmed that likely all the rooms on the dementia unit needed to have the overhead lighting cleaned.	F 584		
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	F 656		

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F 656	Continued From page 10 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 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 observations, staff interviews and medical record review the facility failed to develop a person-centered comprehensive care plan for 1 of 16 sampled residents (Resident # 51), and failed to ensure the plan is developed and implemented to meet the resident's preferences and goals and addresses the resident's medical, physical, and psychosocial needs. The findings include the following.: Per observation, Isolation Precaution supplies were hanging on the door of Resident #51's room. These supplies are used when a resident has a condition that can be passed to others through droplet, airborne, or contact with the infectious organism.	F 656	F 656 1. Patient 51 was affected by this deficient practice. The IDT reviewed and revised the comprehensive care plan to ensure that the plan reflects the resident's preferences and goals and addresses the resident's medical, physical and psychosocial needs. 2. All patients have the potential to be affected by this deficient practice. The IDT reviewed and revised all comprehensive care plan to ensure that the plan reflects the resident's preferences and goals and addresses the resident's medical, physical and psychosocial needs. 3. The DON/Educator will re-educate all clinical staff on how to develop a comprehensive care plan that includes preferences, goals and medical, physical and psychosocial needs. 4. The DON/Designee will audit the care plans weekly x3 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 6/2/2019 F656 POC accepted 5/30/19 LLovellPN/RMC	

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F 656	Continued From page 11 Per record review, Resident #51 was admitted to the facility on 3/14/19 with VRE (Vancomycin Resistant Enterococcus, a resistant strain of bacteria). A care plan was initiated on 3/14/19 for "history of VRE", with the goal identified as "will be free from injury related to VRE." The intervention implemented is "will take medications as ordered for VRE". An MDS (Minimum Data Set, a comprehensive assessment tool used to determine a resident's functional capabilities and health needs) completed on 4/5/19 reflects that the resident is frequently incontinent of bowel. The resident's care plan did not reflect the need or type of precautions that should be used when caring for the resident or that the resident was frequently incontinent of bowel. On 5/07/19 at 1:28 PM during an interview with the Registered Nurse (RN) confirmation was made that the care plan did not reflect the type of precautions or frequent incontinence of bowel. Per interview with a Licensed Nursing Assistant on 05/07/19 at 3:15 PM s/he reported that s/he was not sure what infection the resident had, but the isolation precaution supplies on the resident's door are there because the nurses use them when they catheterize him/her. Resident # 51 also had a care plan initiated on 3/27/19 that states "The resident has a terminal prognosis r/t (related to)" there is no problem listed after r/t to indicate why the resident's prognosis is terminal. There is also no goal listed on the care plan and the only intervention identified is "Encourage support system of family and friends."	F 656		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 12 On 05/07/19 at 3:58 PM during an interview with the RN s/he confirmed that the care plan was not an accurate reflection of the resident's condition, nor was it developed in accordance with the resident's goals and needs.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review	F 657	F657 1. Patients 3, 10, & 51 was affected by this deficient practice. The IDT reviewed and revised the care plans to ensure that the plan reflects the resident's actual status. 2. All patients have the potential to be affected by this deficient practice. The IDT reviewed and revised all comprehensive care plan to ensure that the plan reflects the resident's actual status. 3. The DON/Educator will re-educate all clinical staff on how to revise care plans to ensure that they reflect the resident's actual status. 4. The DON/Designee will audit the care plans weekly x3 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 6/2/2019 F657 POC accepted 5/30/19 Lloyd RN/PMC	

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F 657	Continued From page 13	F 657		

and staff interview the facility failed to assure that the plan of care was revised to reflect the actual status for 3 of 16 sampled residents (Resident #3, #10, & #51) findings include:

1. Per record review, Resident #3 had a care plan for anticoagulant therapy; however, the resident had no current physician order for an anticoagulant. In interview with the Registered Nurse (RN) s/he indicated that the resident's anticoagulant was discontinued on 12/11/18 but the care plan was never updated to reflect this change.

#2 Per record review, Resident #10's had a care plan for diuretic therapy; however, the resident had no current physician order for a diuretic. In interview with the RN s/he indicate that the resident's diuretic therapy was discontinued on 4/24/18, but the care plan was never updated to reflect this change.

3. Per record review, Resident #51 had a care plan initiated on 3/15/19 that stated "intermittent catheterization and performs self cath to empty bladder" with the goal "will maintain independence with self cath." There is a Physicians order for nursing to straight catheterize twice daily.

On 5/7/19 at 1:28 PM, during an interview with the RN, confirmation was made that Resident #51 no longer self-catharizes and that there is a physician's order for nursing to straight Cath twice daily. The RN also confirmed that Resident #51's care plan was not updated to reflect that nursing staff is actually performing catherization twice daily.

Resident #51 also had a care plan initiated on

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F 657	Continued From page 14 3/27/19 for terminal prognosis. The resident began receiving Hospice services on 4/26/19. The care plan was not updated to reflect this change. On 05/07/19 at 3:58 PM during an interview with the RN s/he confirmed that the resident began receiving Hospice services on 4/26/19 and the care plan was not updated to reflect this change.	F 657		