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

August 27, 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 **August 13, 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

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 08/13/2019

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 unannounced on-site entity reported incident investigation was conducted between 8/12 and 8/13/19 by the Division of Licensing and Protection. There were findings of regulatory violations.	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 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and record review, the facility failed to ensure that two of four residents in the applicable sample were free from abuse; Resident #1 from verbal, mental abuse and Resident #2 from physical abuse. Findings include: 1.) On 7/29/19 a report was made to administration, by a staff member, about an incident that occurred on 7/28/19. The staff member was visiting a family member and Resident #1 asked to speak with them and was	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mike Rines	Administrator	8/22/19

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 600	Continued From page 1	F 600		

very upset and told him/her that a Registered Nurse (RN) had been very rude to him/her and was always mean to them. Resident #1 further told the staff member that when s/he went to get coffee in the Huntington's club (an area designated for Huntington's Disease (HD) residents and a meeting area for residents that need access to the designated smoking area) the RN told him/her that they couldn't have coffee because s/he didn't have HD and this upset the resident because it had never been a problem to get a cup of coffee before. The resident continued to tell the staff member that earlier s/he had gotten a phone call and the RN referred to the caller with profanity. Interview at 10:35 AM on 8/12/19 with a Licensed Nursing Assistant (LNA) that was present during the phone call incident, the RN answered the phone and got upset because s/he had to answer the phone, which was for Resident #1 and without placing the caller on hold, made a derogatory remark using profanity. The LNA stated that Resident #1 was at the nurse station, where the phone call was taken, and s/he saw that Resident #1 became sad and the LNA felt that it was very disrespectful. The LNA further stated another incident that happened that day involving the RN and Resident #1 involving not being allowed coffee (the resident is not on restrictions to drink coffee). S/he stated that later in the day Resident #1 was in the lunch room and was crying, Resident #1 told the LNA that s/he didn't understand why the RN didn't like him/her and didn't know why the RN was so upset with him/her. Interview with Resident #1 on 8/12/19 at 1:05 PM, s/he stated that there was a phone call for him/her and the RN used profanity to report who was on the phone and it made him/her sad to hear the RN

F600

1. Resident #1 and # 2 was affected by this deficient practice. Nurse involved with resident # 1 resigned from facility. Resident # 2 had no further interaction with the other resident #5. Heighten staff awareness of distant supervision in common areas for redirection and offering other activity options of residents for potential interactions.

2. All patients have the potential to be affected by this deficient practice. Heighten staff awareness of distant supervision in common areas

3. The DON/Educator will re-educate all staff of resident rights and abuse and reporting policy. All staff can intervene and redirect.

4. The DON/Designee will audit random shift and times for compliance of following the policy and procedure 4 times a week 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 9/2/2019

F600 POC accepted 8/22/19 BBartell RN/PMC

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F 600	Continued From page 2	F 600		

speak that way about his/her friend. Resident #1 referenced the incident involving his/her wanting a cup of coffee and when the RN told him/her that they couldn't have the coffee, it made him/her start to cry and s/he went back to their room so s/he wouldn't have to interact with the RN because it made him/her feel disrespected and didn't want to hear any more swearing from the RN because s/he found foul language to be abusive. The resident continued to state that the RN had yelled at them before but s/he didn't want to report it, but felt that enough was enough and it had to stop and that is why s/he said something.

2.) On 4/27/19, Resident #2 was ambulating in the main common room on the dementia unit around 10:00 PM and s/he stopped in front of another resident, Resident #4, that was watching television. Resident #4 became upset, stood up and pushed Resident #2, causing him/her to fall on the floor. As a result of Resident #2 being pushed, s/he sustained a four centimeter bruise to the left temporal area. Per record review Resident #4 has a March 2019 monthly progress note indicates that s/he becomes easily annoyed if another resident tries to get into his/her room or in his/her space. His/her care plan, initiated 9/27/2017 indicates that Resident #4 has a potential to be physically aggressive towards others related to dementia and poor tolerance for other residents at times. Resident #2 has a care plan that states that there is a history of behaviors that requires distant supervision and verbal cues for redirection and for destination as needed. The Director of Nursing (DNS) confirmed in an interview on 8/13/19 at 11:30 AM that Resident #2 requires distant supervision and redirection at times and Resident #5 can sometimes have aggressive behavior towards others as indicated

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F 600	Continued From page 3 in their care plans. S/he also confirmed that there was no staff in the common room when the incident happened and the Licensed Nursing Assistant that reported the incident had just come into the room when the resident was pushed.	F 600		
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 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:	F 609	F609 1. Employee involved in abuse is no longer employed by facility 2. No other employee's identified as being suspicion of abuse at this time 3. DON provided education to all staff on importance of reporting any suspicion of abuse per the reporting guidelines 4. DON will audit 100 % of subsequent allegations of abuse to insure reported per the guidelines. 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 9/2/2019 F609 POC accepted 8/22/19 RBoteuRN/PMC	

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F 609	Continued From page 4 Based on staff interview and record review, the facility failed to ensure that an allegation of verbal abuse was reported to the State Agency within 24 hours of the incident. Findings include: On 7/28/19 there was a concern voiced to a staff member from a resident that indicated a concern regarding verbal abuse. The staff member did not report the allegations to the anyone until 7/29/19, at which time s/he reported it to the administrator and the Director of Nursing Services. An internal investigation was started but the allegation was not reported to the State Agency until 7/30/19. Per interview with the administrator on 8/12/19 at 2:30 PM s/he confirmed that it had not been reported immediately. Per the staff that it was first reported to the resident told them that they felt like s/he was being verbally and mentally abused by a Registered Nurse.	F 609		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that medically-related social services was provided to three residents in the applicable sample, Resident #1, 2 and 3, to maintain the highest practicable mental and psychosocial well-being following an allegation of verbal abuse. Findings include: 1.) On 7/28/19 Resident #1 reported to a staff	F 745		

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F 745	Continued From page 5	F 745		

member that s/he felt like s/he had been verbally and mentally abused by a Registered Nurse earlier in the day and the staff member reported the allegation to the administrator and Director of Nursing on 7/29/19. The social worker completed a grievance form on 7/29/19 based on what the staff member reported and the facility reported the incident to the State Agency on 7/30/19 following an investigation. Per record review on 8/12/19, there was no evidence that the resident had been seen by social worker or staff regarding his/her psychosocial well-being. Interview with the social worker on 8/12/19 at 12:25 PM, provided confirmation that the social worker had not spoken with the resident regarding the incident because the resident was out of the facility on a leave of absence. The resident returned to the facility 8/2/19, but no one has spoke with him/her or addressed his/her feelings.

2.) On 7/27/19 Resident #3 made an allegation that s/he had been hit on the foot by another resident and per review of the medical record on 8/13/19, there is no evidence that there was a follow-up to his/her psychosocial well being. The social worker confirmed on 8/13/19 at 10:45 AM that there had been no follow up for psychosocial well being for Resident #3.

3.) Resident #2 was involved in an incident on 4/27/19, in which s/he was pushed by another resident and sustained a bruise to his/her left eyebrow. The review of the medical record had no evidence of psychosocial follow up. The social worker confirmed, on 8/13/19 at 10:45 AM, that there had been no follow up for Resident #2.

F745

1. Resident #1, # 2 and #3 affected by this deficient practice. Social Worker documented medically related social service notes as required
2. All residents that have the potential to be effective by this deficient practice have been audited and no others identified
3. The DON met with the Social worker and re-education provided on importance of documenting medically related notes to attain and maintain highest practicable physical, mental and psychosocial well being
4. DON will audit 100 % of subsequent reportable to make sure adequate notes are documented by social worker

Audits as needed next 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 9/2/2019

F745 POC accepted 8/22/19 BBartell RN/PMC