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 6, 2021

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 **March 23, 2021.** 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

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 03/23/2021

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 The Division of Licensing and Protection conducted an onsite, unannounced complaint survey on 3/22/2021. The survey was concluded on 3/23/2021. The following regulatory violations 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 summary statement of deficiencies.	
F 584 SS=D	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 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);	F 584	F 584 In regards to F 584, Resident #1 sustained an unwitnessed fall on 2/20/2021. Resident #1 was found on his/her knees in front of the toilet with the bathroom support bar pulled away from the wall and attached by a few loose screws. Per the record, maintenance was notified and the support bar was removed for repair. To correct this deficient practice-Bathroom Support Bars have been included in the maintenance monthly preventative log checklist in an effort to maximize resident independence and ensure support bars do not pose a safety risk. Audits will be completed weekly x4 weeks then monthly x3 months. Monthly preventative log checklist will be maintained by the maintenance department and these logs will be reported to the QAPI team. All residents that have the potential to be effected by this deficient practice has been audited, and no others identified. Date of compliance: 04/30/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Mike Lewis — Administrator — 5/3/21

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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 584	Continued From page 1 §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, staff interview, and record review the facility failed to ensure that the physical layout and facility equipment does not pose a safety risk for 1 of 10 sampled residents (Resident #1). 1. Per record review, Resident #1 sustained an unwitnessed fall on 2/20/2021. Resident #1 was found on his/her knees in front of the toilet with the bathroom support bar pulled away from the wall and attached by a few loose screws. Per the record, maintenance was notified and the support bar was removed for repair. Per observation of Resident #1's bathroom, the bathroom support bar was affixed to the wall next to the toilet several inches below a depression in the wall from a previously-placed support bar. Per review of the monthly preventative maintenance logs, the bathroom support bars are not included in the facility's monthly preventative maintenance checklist. This was confirmed during an interview with the Administrator and the Maintenance Director on 3/23/2021 at approximately 3:00 PM.	F 584	F584 POC accepted 5/4/21 SFreeman RN/ PMC	

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F 584	Continued From page 2 2. Per interview with Resident #1 on 3/22/2021 at 1:15 PM, he/she stated that the call light was not working. During observation of resident #1's call light use, it was confirmed that Resident #1's call light was malfunctioning. Per review of Resident #1's care plan, Resident #1 is to have the call light within reach for use. However, there are no interventions in Resident #1's care plan regarding his/her tampering with his/her call bell wall unit. Per interview with the Staff Educator, Resident #1 is known to tamper with the call light attached to the wall in his/her room. Per review of preventive maintenance audits provided by the Maintenance Director, the maintenance department does perform monthly audits on all call lights to ensure they have not malfunctioned. However, there is no evidence of increased monitoring of Resident #1's call light to ensure that it has not malfunctioned due to his/her known tampering.	F 584	F584 In regards to F584, Resident #1 call light was malfunctioning- Per review of Resident #1's care plan, Resident #1 is to have the call light within reach for use. However, there are no interventions in Resident #1's care plan regarding his/her tampering with his/her call bell wall unit. To correct this deficient practice- Resident's call light will be audited by maintenance department for proper functioning, weekly for 4 weeks, then monthly for 3 months. Care plan will be updated by nursing to reflect resident's known tampering of call bell system in her room. Care plan Intervention will be reviewed at quarterly care plan review and adjusted according to resident's needs.	
F 689 SS=E	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 observation, staff interview, and record review, the facility failed to provide adequate resident assessment and supervision, and failed to implement, modify, and monitor effectiveness of care plan interventions to prevent accidents for	F 689	All residents that have the potential to be effected by this deficient practice has been audited, and no others identified. Date of compliance:04/30/21 F584 POC accepted 5/4/21 SFreeman RN | PMC	

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F 689	Continued From page 3 4 of 10 sampled residents (Resident #1, 2, 3, and 4). Findings include: 1. Per record review, Resident #1 has a diagnoses of Huntington's disease which causes involunatary muscle movements, increasing the risk of falls. Per review of Resident #1's progress notes, Resident #1 experienced falls on 12/11/2020, 12/12/2020, 1/3/2021, 1/7/2021, 1/21/2021, 1/27/2021, 2/3/2021, 2/20/2021, 2/21/2021, and 2/27/2021. The falls that occurred on 12/11/2020, 1/3/2021, 2/3/2021, 2/21/2021, and 2/27/2021 resulted in Resident #1 sustaining lacerations (or cuts) to his/her head. The Director of Nursing (DON) could not produce documented evidence of completed incident/accident reports for the falls that occurred on 12/12/2021, 1/21/2021, 1/27/2021, 2/20/2021, and 2/27/2021. Per interview with the Staff Educator on 3/22/2021 at 1:50 PM, a resident found on the floor without witness to the events leading them to be on the floor should activate the post-fall protocol, which includes the completion of an incident/accident report. The DON confirmed during interview on 3/23/2021 at 2:30 pm that per protocol, incident/accident reports should be completed, however there is no evidence that staff completed them after each fall. Of the incident/accident reports that could be produced, none of them had the section "interventions to prevent re-occurrences" completed. 2. Per review of Resident #1's risk for falls care plan, only 1 of 28 listed interventions had been added or revised since 1/05/2021. The most recent revised or added intervention prior to that	F 689	F689 In regards to F689, Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, staff interview, and record review, the facility failed to provide adequate resident assessment and supervision, and failed to implement, modify, and monitor effectiveness of care plan interventions to prevent accidents for 4 of 10 sampled residents (Resident #1, 2, 3, and 4). To correct this deficient practice-1) the DON (and/or designee) will audit facility wide falls for completion of incident/accident reports. Audits will take place weekly for 4 weeks then monthly for 3 months. 2)Education will be provided to all staff on incident/accident report completion. 3)Incident/accident reports will be reviewed with an IDT at daily morning meeting and care plan interventions reviewed and updated accordingly. 4) IDT will conduct weekly Falls Meeting. In regards to resident #1 – Review of resident at falls meeting and care plan updated with current interventions. Guidance provided to assist staff in assessing to determine whether a fall occurred vs placing self on floor. Date of compliance:04/30/21	

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F 689		F 689		

Continued From page 4 was done on 9/8/2020. 3 of the 28 listed interventions contain information about the resident without explanations of what actions staff are to take in order to prevent falls, such as the intervention "at times I will put myself on the floor." with no guidance for staff on what to do if the resident is found on the floor.

Per interview with a Physical Therapist (PT) on 3/23/2021 at 12:00 PM, the facility had implemented and trialed several interventions to decrease the risk of Resident #1 falling. These included trialing fall mats in Resident #1's room as well as removing the toilet paper roll holder to prevent Resident #1 from using it as a support. Per review of a PT encounter note from 6/17/2020, "Trialed floor mat in patient room due to impulsivity and poor safety awareness; however, presence of floor mat increases fall risk due to tripping hazard. Removed floor mat from patient room." Per review of Resident #1's care plan, there is no mention of the recommendation against floor mats or the removal of the toilet paper holder in the care plan.

3. Resident #1 is known to place him/herself on the floor per review of Resident #1's care plan and consistent documentation within progress notes. There is no evidence of information contained in the resident's record regarding how to confirm that Resident #1 has placed him/herself on the floor as opposed to having sustained a fall.

Per the facility's policy on Falls Prevention and Protocol Guidelines, a fall is defined as "an unplanned descent to a lower level assisted or unassisted with or without injury." The Resident Assessment Instrument User's Manual states,

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F 689		F 689		

Continued From page 5

"unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred." The facility's policy on Falls Prevention and Protocol Guidelines instructs the nurse to "complete the incident/accident report, including the back page."

Per observation of the lunch service on 3/22/2021 at 12:00 PM, while an LNA was delivering Resident #1's lunch tray into his/her room, the LNA found Resident #1 laying on the floor behind the door. The door was slightly ajar and prior to the LNA entering the room, Resident #1's legs were observed on the floor. Before entering the room, the LNA was asked about Resident #1 being on the floor, the LNA stated "Oh, that's just [name of Resident #1], [he/she] likes being on the floor." The LNA did not ask Resident #1 if he/she had fallen or if he/she was injuried. The LNA did not alert the nurse that the resident had been found on the floor, nor was the resident assessed by a nurse for injury.

Per interview with an RN on 3/22/2021 at 1:40 PM, when asked how they would determine if Resident #1 had sustained a fall or if he/she had placed his/herself on the floor if it was an unwitnessed lowering to the floor, the RN stated that they would look for blood, injuries, or parts of the resident environment that were broken.

Per interview with a Licensed Nursing Assistant (LNA) on 3/23/2021 at 1:00 PM, when asked how they would determine if Resident #1 had sustained a fall or if he/she had placed his/herself on the floor if it was an unwitnessed lowering to the floor, the LNA stated that he/she can't always tell the difference.

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F 689	Continued From page 6 4. Per interview with Resident #1 on 3/22/2021 at 1:15 PM, he/she stated that the call light was not working. During observation of resident #1's call light use, it was confirmed that Resident #1's call light was malfunctioning. Per review of Resident #1's care plan, Resident #1 is to have the call light within reach for use. However, there are no interventions in Resident #1's care plan regarding his/her tampering with his/her call bell wall unit. Per interview with the Staff Educator, Resident #1 is known to tamper with the call light attached to the wall in his/her room. Per review of preventive maintenance audits provided by the Maintenance Director, the maintenance department does perform monthly audits on all call lights to ensure they have not malfunctioned. However, there is no evidence of increased monitoring of Resident #1's call light to ensure that it has not malfunctioned due to his/her known tampering. 5. Per review of progress notes for Resident #2, Resident #2 experienced a fall on 12/2/2020 in which he/she sustained a laceration to the head and bruising. The DON could not produce documented evidence of a completed incident/accident report for this fall. The DON confirmed during interview on 3/23/2021 at 2:30 PM that there was no incident/accident report completed for the 12/2/2020 fall, which is typically used to assess/document/investigate the circumstances and determine if new interventions are needed to prevent further falls or injury. 6. Per record review, Resident #3 was admitted in 2019 with diagnoses including early onset Alzheimer's disease, anxiety disorder, major depressive disorder, and cognitive communication deficit. Per resident care plan	F 689		

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F 689	Continued From page 7 focus initiated on 9/13/2019, Resident #3 has potential to be physically aggressive related to dementia and is at risk for physical abuse from others. Resident #3 has had altercations involving other residents on 4/19/2020, 5/27/2020, 6/19/2020, 8/13/2020, 8/29/2020, 10/19/2020, and 12/12/2020. New interventions related to this care plan focus were implemented on 1/6, 6/22, and 8/13/2020 however, there were no new interventions implemented after the 4/19, 5/27, 8/29, 10/19, or 12/12/2020 incidents. On 6/22/2020 Resident #3's care plan was updated to reflect that he/she becomes upset with abrupt redirection from staff or others and will stomp his/her feet, kick at walls, and push/pull tables. Interventions listed include staff to be aware of the resident's wandering and redirect away from other's who find him/her intrusive, and staff members to place barriers in front of doorways as indicated or resident's wishing not to be disturbed by wandering resident i.e., half door. Per interview with an LPN on 3/22/2021 at 2:45 PM, s/he reported that Resident #3 opens the half doors and when s/he becomes frustrated s/he yanks and slams them. There is no care planned interventions that address this behavior. Per the facility reported statement written by the previous DON, and a nurses note written on 8/29/2020 at 8:51 PM, Resident #3 was involved in an unwitnessed altercation with another resident who was found sitting on the floor outside his/her room. The other resident reported that he/she was "trying to get [Resident #3] out of out of [his/her] room and [Resident #3] pushed [hm/her]" causing him/her to fall. A care plan note dated 8/31/2020 at 11:42 am written by the Unit Manager, states the care plan was "reviewed with	F 689	In regards to F689, Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, staff interview, and record review, the facility failed to provide adequate resident assessment and supervision, and failed to implement, modify, and monitor effectiveness of care plan interventions to prevent accidents for 4 of 10 sampled residents (Resident #1, 2, 3, and 4). To correct this deficient practice- 1)Education will be provided to all staff on Dementia behavior and aggression prevention and then ongoing quarterly per regulation 2)Behaviors will be reviewed with an IDT at daily morning meeting and care plan interventions reviewed and updated accordingly. 3)Increased supervision by staff to assist in monitor resident's interaction in the Dementia Care Unit. All residents on the Memory Care Unit have the potential to be effected by this practice related to DX Dementia. Education provided to staff regarding awareness, to be alert to potential negative reactions or interactions. Date of compliance:04/30/21 F689 POC accepted 5/4/21 SFreeman RN | PMC	

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F 689	Continued From page 8 no update required at this time" although the interventions from the 6/22/2020 care plan were not effective in preventing Resident #3 from wandering into other resident's rooms. On 10/19/2020 Resident #3 was ambulating independently throughout the unit as she does at her baseline. [He/She] proceeded to wander into another resident's room. At that time [the other resident] began yelling at [Resident #3, who] becomes upset when people are yelling or raise their voices. Resident #3 then threw some milk in [the other resident's] face. [The other resident] then reacted by shoving [Resident #3] causing [him/her] to lose balance and fall. Per review, the care plan was updated on 10/19/2020 to reflect that Resident #3 had an "Altercation with another resident" however there were no new interventions added to protect Resident #3 from wandering into other's rooms, being the recipient of aggression, or becoming aggressive toward other residents. On 12/12/2020 care plan still not updated to reflect need for increased supervision. Per nurses note written by the Staff Educator on 12/12/2020 at 7:01 PM Resident #3's care plan was reviewed, and interventions remain appropriate. On 3/22/2021 at 2:45pm during an interview with a LPN, he/she reported that Resident #3 has aggressive behaviors and is often triggered by being told no. Resident #3 is known to be aggressive towards staff and other residents with or without being provoked. The LPN states that "sometimes [he/she] just walks up to you and becomes aggressive for no reason". When asked about Resident #3's wandering into other's rooms and what type of supervision is in place, s/he	F 689		

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F 689	Continued From page 9 stated that they do have the half doors to discourage residents from going into other's rooms. Sometimes when Resident #3 is angry he/she yanks and pushes on the doors, and there is no specific plan that they follow. "we just get to know the resident and know what to do". The LPN confirmed that Resident #4 is not on any specific safety checks during the shift, stating "We just say to each other has anybody seen so and so? We just know where the residents are or go look for them if we haven't seen them in a while." The LPN reports that staff are told to redirect Resident #3 from other resident rooms when they see him/her entering another resident's room. The LPN states that staff do not monitor whereabout of resident #3 on a scheduled basis.	F 689		