Division of Licensing and Protection HC 2 South, 280 State Drive Waterbury, VT 05671-2060 <u>http://www.dail.vermont.gov</u> 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,

Jamela Mcota RN

Pamela M. Cota, RN Licensing Chief

PRINTED: 04/05/2021 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A, BUILDIN		C		
		475033	B. WING		03/23/2021	
NAME OF PI	ROVIDER OR SUPPLIER		p. mild	STREET ADDRESS, CITY, STATE, ZIP CODE		
CRESCEN	IT MANOR CARE CTRS			312 CRESCENT BLVD BENNINGTON, VT 05201		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO		
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	DATE	
F 000			F 0			
	INITIAL COMMENTS	3		The following constitutes the F response to the findings of The Dep		
				of Licensing and does not consti	tute an	
		sing and Protection conducted an complaint survey on 3/22/2021.		admission of guilt or agreement of t alleged or conclusions set for su		
	The survey was conc	luded on 3/23/2021. The following		statement of deficiencies.	,	
	regulatory violations	were identified:		F 584		
F 584	Safe/Clean/Comforta	ble/Homelike Environment	F 5			
SS=D	CFR(s): 483.10(i)(1)-			In regards to F 584, Resident #1 susta		
	§483.10(i) Safe Envir	roomont		unwitnessed fall on 2/20/2021. Resid was found on his/her knees in from		
	The resident has a right			toilet with the bathroom support bar	pulled	
	comfortable and hom	elike environment, including		away from the wall and attached by loose screws. Per the record, main	a few	
	but not limited to rece supports for daily livin			was notified and the support ba		
				removed for repair.		
	The facility must prov	ride- clean, comfortable, and		To correct this deficient practice-Ba	throom	
		nt, allowing the resident to		Support Bars have been included	in the	
	use his or her person	al belongings to the extent		maintenance monthly preventativ checklist in an effort to maximize r	ve log	
	possible. (i) This includes ensu	ring that the resident can		independence and ensure support l		
	receive care and serv	vices safely and that the		not pose a safety risk.		
		facility maximizes resident bes not pose a safety risk.		A 199 THE LEVEL AND A STAR AND A STAR	master	
		xercise reasonable care for		Audits will be completed weekly x4 then monthly x3 months.	WCERS	
	the protection of the I	resident's property from loss				
	or theft.			Monthly preventative log checklist maintained by the maintenance depa	will be	
		eeping and maintenance		and these logs will be reported to the	e QAPI	
	services necessary to and comfortable inter	o maintain a sanitary, orderly,		team.		
				All residents that have the potentia	1 to be	
		ed and bath linens that are		effected by this deficient practice has		
	in good condition;		(	audited, and no others identified.		
	§483.10(i)(4) Private			Date of compliance: 04/30/21		
	resident room, as spe	ecified in §483.90 (e)(2)(iv);				
LABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATURE	C	TITLE	(X6) DATE	
	Mile Lin	ک ہو		Alwinistate	5/3/21	

#### PRINTED: 04/05/2021 FORM APPROVED OMB NO, 0938-0391

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:P07011

Facility ID: 475033

If continuation sheet Page 1 of 10

STATEMENT OF DERIGENCES       [K1]       PROVIDER/SUPPLIER       A BUILDING       Image: Construction of Co			(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE		
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Maintenance Director on 3/23/2021 at		maintenance checkli	ist. This was confirmed						
		Maintenance Directo	or on $3/23/2021$ at						

PRINTED: 04/05/2021 FORM APPROVED

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

		MEDICAID SERVICES			O. 0938-	0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE COMPI	LETED	
		475033	B. WING			) 3/2021
	ROVIDER OR SUPPLIER		31	REET ADDRESS, CITY, STATE, ZIP CODE 2 CRESCENT BLVD ENNINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETI DATE
F 584			F 584	F584		
F 689 SS=E	1:15 PM, he/she stat working. During obse light use, it was confi light was malfunction #1's care plan, Resid light within reach for interventions in Resid his/her tampering with Per interview with the is known to tamper w the wall in his/her roo maintenance audits p Director, the mainten perform monthly aud they have not malfur no evidence of increa #1's call light to ensu- malfunctioned due to Free of Accident Haz CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensis §483.25(d)(2)Each m supervision and assis accidents. This REQUIREMEN by: Based on observation review, the facility far resident assessment to implement, modify	Resident #1 on 3/22/2021 at ed that the call light was not ervation of resident #1's call rmed that Resident #1's call ing. Per review of Resident lent #1 is to have the call use. However, there are no dent #1's care plan regarding h his/her call bell wall unit. e Staff Educator, Resident #1 vith the call light attached to om. Per review of preventive provided by the Maintenance nance department does its on all call lights to ensure loctioned. However, there is ased monitoring of Resident ire that it has not o his/her known tampering. cards/Supervision/Devices 1(2)	F 689	In regards to F584, Resident #1 call ligh malfunctioning- Per review of Residen care plan, Resident #1 is to have the cal within reach for use. However, there a interventions in Resident #1's care regarding his/her tampering with his/h bell wall unit. To correct this deficient practice- Resi call light will be audited by mainted department for proper functioning, v for 4 weeks, then monthly for 3 months plan will be updated by nursing to resident's known tampering of cal system in her room. Care plan Interv will be reviewed at quarterly care plan p and adjusted according to resident's new All residents that have the potential	tt #1's Il light are no e plan er call ident's enance veekly s. Care reflect il bell ention review seds. to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
FORM CMS-2567(02-99) Previous Versions O	Dbsolete Event ID:P07011	Facility ID: 475033 If continuation	n sheet Page 3 of 10

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JENTER:	S FOR MEDICARE & MEDI	OR MEDICARE & MEDICAID SERVICES		CIVID I	10. 0938 	C
		475033	B. WING		03/2	3/2021
AME OF PI	ROVIDER OR SUPPLIER	475055	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				12 CRESCENT BLVD		
CRESCEN	T MANOR CARE CTRS		B	ENNINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 689			F 689			
1 003				F689		
	Continued From page 3			1005		
	4 of 10 sampled residents	(Resident #1, 2, 3, and		In regards to F689, Each resident rec	eives	
	4), Findings include:	(reducion in r) =] of and		adequate supervision and assistance		
	'/'''			devices to prevent accidents. Based o	n	
	1. Per record review, Resi	dent #1 has a		observation, staff interview, and reco		
	diagnoses of Huntington's	disease which causes		review, the facility failed to provide		
	involunatary muscle move			adequate resident assessment and		
	risk of falls. Per review of			supervision, and failed to implement,		1
	notes, Resident #1 experie		1	modify, and monitor effectiveness of	care	
	12/11/2020, 12/12/2020, 1			plan interventions to prevent accider	nts for	
	1/21/2021, 1/27/2021, 2/3			4 of 10 sampled residents (Resident -	#1,2,	
	2/21/2021, and 2/27/2021.			3, and 4).		
	on 12/11/2020, 1/3/2021, 3 and 2/27/2021 resulted in					
	lacerations (or cuts) to his			To correct this deficient practice-	LJ the	
	of Nursing (DON) could no	ot produce documented		DON (and/or designee) will audit f wide falls for completion	of	
	evidence of completed inc			incident/accident reports. Audits wi	ll take	
	for the falls that occurred of			place weekly for 4 weeks then month	hly for	
	1/21/2021, 1/27/2021, 2/2	0/2021, and 2/27/2021.		3 months. 2)Education will be provi	ded to	
				all staff on incident/accident	report	
	Per interview with the Stat			completion. 3)Incident/accident r	eports	
	3/22/2021 at 1:50 PM, a re floor without witness to the			will be reviewed with an IDT at		
	to be on the floor should a		1	morning meeting and care interventions reviewed and up	plan bdated	
	protocol, which includes the			accordingly. 4) IDT will conduct v	veekly	
	incident/accident report.			Falls Meeting.		
	The DON confirmed durin			In regards to resident #1 - Revi	ew of	
	3/23/2021 at 2:30 pm that incident/accident reports s			resident at falls meeting and care	e plan	
	however there is no evide	nce that staff completed	{	updated with current interve	aff in	
	them after each fall. Of the	e incident/accident		Guidance provided to assist st assessing to determine whether	a fall	
	reports that could be prod			occurred vs placing self on floor.		
	the section "interventions					
	occurrences" completed.			Date of compliance:04/30/21		
	2. Per review of Resident	#1's risk for falls care				
	plan, only 1 of 28 listed in					
	added or revised since 1/0	05/2021. The most				
	recent revised or added in				_	1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	A A. BUILDING	(X3) DATE SURVEY COMPLETED
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Event ID:P07011

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OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		OMBI	VO. 0938-0391
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		475033	B. WING		03/23/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				312 CRESCENT BLVD BENNINGTON, VT 05201	
CRESCEN	IT MANOR CARE CTRS				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE CONFLECTION
F 689			Fe	389	
	of the 28 listed interv about the resident wi actions staff are to ta such as the intervent on the floor." with no to do if the resident is Per interview with a l 3/23/2021 at 12:00 F implemented and tria decrease the risk of included trialing fall r as well as removing prevent Resident #1 Per review of a PT e 6/17/2020, "Trialed f to impulsivity and po however, presence of due to tripping hazar patient room." Per re plan, there is no mer against floor mats or paper holder in the o	Physical Therapist (PT) on PM, the facility had aled several interventions to Resident #1 falling. These mats in Resident #1's room the toilet paper roll holder to from using it as a support. incounter note from loor mat in patient room due for safety awareness; of floor mat increases fall risk rd. Removed floor mat from eview of Resident #1's care intion of the recommendation the removal of the toilet care plan.			
	the floor per review of and consistent docu notes. There is no efficiency contained in the residute to confirm that Residute	own to place him/herself on of Resident #1's care plan mentation within progress vidence of information ident's record regarding how dent #1 has placed oor as opposed to having			
	Protocol Guidelines, unplanned descent unassisted with or w	cy on Falls Prevention and , a fall is defined as "an to a lower level assisted or <i>r</i> ithout injury." The Resident nent User's Manual states,			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
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Event ID:P07011

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	S FOR MEDICARE & MEE	ICAID SERVICES	Ĩ.		OMB NO. 09	C
		475033	B. WING		0.	3/23/2021
	OVIDER OR SUPPLIER	473033	B. WING	STREET ADDRESS, CITY, STAT 312 CRESCENT BLVD BENNINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETI DATE
F 600			F 68			
	Continued From page 5 "unless there is evidence when a resident is found considered to have occur on Falls Prevention and F instructs the nurse to "co incident/accident report, i Per observation of the lur at 12:00 PM, while an LN Resident #1's lunch tray LNA found Resident #1 Is the door. The door was s the LNA entering the roor were observed on the flo room, the LNA was aske being on the floor, the LN [name of Resident #1], [F floor." The LNA did not a had fallen or if he/she wa not alert the nurse that the found on the floor, nor wa by a nurse for injury. Per interview with an RN PM, when asked how the Resident #1 had sustaine placed his/herself on the unwitnessed lowering to that they would look for b the resident environment Per interview with a Licer (LNA) on 3/23/2021 at 1: they would determine if F sustained a fall or if he/sl on the floor, the LNA stated tell the difference.	on the floor, a fall is red." The facility's policy Protocol Guidelines mplete the ncluding the back page." A was delivering nto his/her room, the aying on the floor behind lightly ajar and prior to m, Resident #1's legs or. Before entering the d about Resident #1 IA stated "Oh, that's just re/she] likes being on the sk Resident #1 if he/she s injuried. The LNA did e resident had been as the resident assessed on 3/22/2021 at 1:40 by would determine if ed a fall or if he/she had floor if it was an the floor, the RN stated kood, injuries, or parts of that were broken. heed Nursing Assistant 00 PM, when asked how Resident #1 had he had placed his/herself mwitnessed lowering to				

) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
BUILDING	COMPLETED

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-03	OMB NO. 0938-0391	
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		475033	B. WING		03/23/2	021
	T MANOR CARE CTRS			STREET ADDRESS, CITY, STATE, ZIP C 312 CRESCENT BLVD BENNINGTON, VT 05201	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE	(X5) MPLET DATE
F 689	Continued From page 6		F 6	89		
	4. Per interview w	ith Resident #1 on e/she stated that the call				
	resident #1's call light u Resident #1's call light v review of Resident #1's	se, it was confirmed that was malfunctioning. Per care plan, Resident #1 is to				
	there are no interventio	reach for use. However, ns in Resident #1's care ampering with his/her call				
	is known to tamper with the wall in his/her room	taff Educator, Resident #1 the call light attached to . Per review of preventive vided by the Maintenance				
	Director, the maintenan perform monthly audits they have not malfuncti	ce department does on all call lights to ensure oned. However, there is				
	no evidence of increase #1's call light to ensure malfunctioned due to hi	ed monitoring of Resident that it has not s/her known tampering.				
	#2, Resident #2 experie	rogress notes for Resident enced a fall on 12/2/2020 in a laceration to the head could not produce				
	documented evidence	of a completed for this fall. The DON iew on 3/23/2021 at 2:30	-			
	completed for the 12/2/ used to assess/docume	2020 fall, which is typically ent/investigate the ermine if new interventions				
		iew, Resident #3 was				
	2019 with diagnoses in Alzheimer's disease, an depressive disorder, ar	nxiety disorder, major nd cognitive				
	communication deficit.	Per resident care plan				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED C
	475033	B. WING	03/23/2021

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 312 CRESCENT BLVD BENNINGTON, VT 05201 CRESCENT MANOR CARE CTRS PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 689 F 689 In regards to F689, Each resident receives adequate supervision and assistance Continued From page 7 focus initiated on devices to prevent accidents. Based on 9/13/2019, Resident #3 has potential to be observation, staff interview, and record physically aggressive related to dementia and is at risk for physical abuse from others. Resident review, the facility failed to provide adequate resident assessment and #3 has had altercations involving other residents on 4/19/2020, 5/27/2020, 6/19/2020, 8/13/2020, supervision, and failed to implement, modify, and monitor effectiveness of care 8/29/2020, 10/19/2020, and 12/12/2020. New interventions related to this care plan focus were plan interventions to prevent accidents for implemented on 1/6, 6/22, and 8/13/2020 4 of 10 sampled residents (Resident #1, 2, however, there were no new interventions 3, and 4). implemented after the 4/19, 5/27, 8/29, 10/19, or 12/12/2020 incidents. correct this deficient practice-Τo 1)Education will be provided to all staff on On 6/22/2020 Resident #3's care plan was behavior aggression and Dementia updated to reflect that he/she becomes upset with prevention and then ongoing quarterly per regulation 2)Behaviors will be reviewed abrupt redirection from staff or others and will stomp his/her feet, kick at walls, and push/pull with an IDT at daily morning meeting and care plan interventions reviewed and tables. Interventions listed include staff to be aware of the resident's wandering and redirect accordingly. 3)Increased updated supervision by staff to assist in monitor away from other's who find him/her intrusive, and resident's interaction in the Dementia Care staff members to place barriers in front of doorways as indicated or resident's wishing not to Unit. be disturbed by wandering resident i.e., half door. Per interview with an LPN on 3/22/2021 at 2:45 All residents on the Memory Care Unit have PM, s/he reported that Resident #3 opens the half the potential to be effected by this practice doors and when s/he becomes frustrated s/he related to DX Dementia. Education provided yanks and slams them. There is no care planned to staff regarding awareness, to be alert to interventions that address this behavior. potential negative reactions or interactions. 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 Date of compliance:04/30/21 in an unwitnessed altercation with another resident who was found sitting on the floor F689 PDC accepted 5/4/21 outside his/her room. The other resident reported that he/she was "trying to get [Resident SFreeman PN/PML #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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SURVEY COMPLETED C
	475033	B. WING	03/23/2021

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	S FOR MEDICARE & MEDICAID SERVICES		OMB NO. ( STREET ADDRESS, CITY, STATE, ZIP CODE	
	ROVIDER OR SUPPLIER		BIREET ADDRESS, CITY, STATE, ZP 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) COMPLET DATE
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED C
	475033	B, WING	03/23/2021

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

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 (X5) (EACH CORRECTIVE AGTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
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 68			