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

August 17, 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 **June 9**, **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

TATEMENT O	F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONST			(X3) DATE COMF	PLETED
		475033	B. WING	;×	1		1	C 09/2021
	ROVIDER OR SUPPLIER		31		ADDRESS, CITY, ST SCENT BLVD IGTON, VT 0520			21
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTI CTIVE ACTION SHOUL NCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000		2. 2.			
	conducted an annua survey on 6/9/21. Th deficiencies were cit Develop EP Plan, Re	nsing and Protection l emergency preparedness e following regulatory ed as a result: eview and Update Annually	E 004	1i. 2. 3.	practice. All residents alleged defici	were affected by have the potentia ient practice. ensive review	al to be affe	cted by the
SS=C	§483.475(a), §484.1 §485.625(a), §485.7 §486.360(a), §491.1	4(a), §482.15(a), §483.73(a), 02(a), §485.68(a), 27(a), §485.920(a),		ŋ	Emergency I 7/6/21 by the The Adminis by the Region the required Preparedness The Admini	Preparedness pla Administrator, a trator, Education hal Administrator ment to revio Plan at least ann strator or desi lan to the quarte	in was com nd Education Nurse wer on 7/6/202 ew the lually. gnee will	npleted on on Nurse. e educated I regarding Emergency bring the
	develop establish an emergency prepared requirements of this	ements. The [facility] must d maintain a comprehensive lness program that meets the section. The emergency Im must include, but not be		Sec. 28	review/discus Heads. These heads and rev on an ongoing The Administ plan on an an	ss necessary upd updates will be a riewed at the follo	lates with I assigned to I owing QA n v the entire gn it has bee	Department Department neeting and emergency en updated.
	and maintain an eme that must be [review	The [facility] must develop ergency preparedness plan ed], and updated at least plan must do all of the		and a second	Emergency F quarters and a has been upda will present committee at	Preparedness Ma as necessary there ated at least annua the results of the least quarterly.	nual quarter eafter to ensu ally. The Ad he audit to The QAPI	rly for two ure the plan ministrator the QAPI committee
	CAH] must comply w State, and local eme	ency Plan. The [hospital or ith all applicable Federal, rgency preparedness hospital or CAH] must			Executive Di Preventionist Worker, MDS	The Medical Dir frector, Director , Environmenta S Coordinator ar iance is achieved	of Nursing al Service nd Dietary I	, Infection s, Social Manager to
	•	ness program that meets the section, utilizing an		. 4	ponsible Person npletion Date:	on: Administrato 7/6/21	r	
BORATORY C	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE	۱		TITLE	i dala		(X6) DATE 07/08/2021

program participation.

Event ID:KN5N11

Facility ID: 475033

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1444-141-441-1411-141-141-1

		ND HUMAN SERVICES MEDICAID SERVICES		2 2	PRINTED: 08/03/202 FORM APPROVE OMB NO 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		475033	B WING_		C 06/09/2021
NAME OF P	ROVIDER OR SUPPLIER			STREAT ADDRESS, CITY, STATE, ZIP CODE	
005005	TRANCE ALES OFF			312 CRESCENT BLVD	
CRESCE	NT MANOR CARE CTRS			BENNINGTON, VT 05201	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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 APPROPRI/ DEFICIENCY)	
E 004 E 013 SS=C	<ul> <li>Plan. The LTC facility an emergency prepareviewed, and update</li> <li>* [For ESRD Facilitie Plan. The ESRD facilitie Plan. The ESRD facilitie Plan. The ESRD facility maintain an emerger must be [evaluated], years.</li> <li>This REQUIREMENT by: Based on staff interview facility failed to ensur- preparedness plan is least annually. Findir</li> <li>Per record review of preparedness plan, the May 28th, 2019.</li> <li>Per interview on June 9:30 am, the facility A the facility has not re emergency prepared and that the facility is regulation.</li> </ul>	at §483.73(a):] Emergency y must develop and maintain redness plan that must be ed at least annually. s at §494.62(a):] Emergency lity must develop and ncy preparedness plan that and updated at least every 2 T is not met as evidenced riew and record review, the re that the emergency reviewed and updated at ngs include:	E 0'	A TAG E 004 POC Accepted on 8/17/21 by P. Cota	
	§403.748(b), §416.54 §441.184(b), §460.84 §483.475(b), §484.10 §485.625(b), §485.72 §486.360(b), §491.12	4(b), §482.15(b), §483.73(b), 02(b), §485.68(b), 27(b), §485.920(b),			

Event ID:KN5N11

Facility ID: 475033

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 If continuation sheet Page 2 of 41

		ID HUMAN SERVICES				FORM	D: 08/03/2021 MAPPROVED
		MEDICAID SERVICES	т				<u>), 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE COMF	SURVEY
		475033	B. WING				C <b>/09/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				3	312 CRESCENT BLVD		
	IT MANOR CARE CTRS			В	BENNINGTON, VT 05201		
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PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
E 013	<ul> <li>(b) Policies and proced develop and impleme policies and procedur plan set forth in parage assessment at parage and the communication this section. The politible reviewed and update *[For LTC facilities at procedures. The LTC implement emergence procedures, based or forth in paragraph (a) assessment at parage and the communication this section. The politible reviewed and update *Additional Requireme Facilities:</li> <li>*[For PACE at §460.8] procedures. The PAC develop and impleme policies and procedur plan set forth in parage and the communication this section. The politible policies and procedures plan set forth in parage and the communication this section. The politible politication this section. The politible politication the politication the politication the politication the politication. The politication the politi</li></ul>	edures. [Facilities] must nt emergency preparedness es, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must ated at least every 2 years. §483.73(b):] Policies and facility must develop and y preparedness policies and the emergency plan set of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must ated at least annually. ents for PACE and ESRD 4(b):] Policies and	E	013	<ol> <li>No residents were affected deficient practice.</li> <li>All residents have the pot by the alleged deficient properties on 7/6/21 by the Administrate Administrator, and Educa 7/6/2021 regarding the review and revise the Emergency Preparedness Plan at leas</li> <li>The Regional Administrate audit the Emergency Preparedness Plan at leas</li> <li>The Regional Administrate audit the Emergency Preparedness preparedness preparedness preparedness preparedness preparedness preparedness preparedness Plan at leas</li> <li>The Regional Administrate audit the Emergency Preparedness preparednes</li></ol>	ential to b actice. Ind updat plan was trator. or educat tion Nurse equireme ergency cannually or or desi aredness quarters a sure the p ually. The t the resu ee at leas hittee cont s designe or of Nurse vironmen DS Coord e complia	e affected te of the completed ed the e on nt to y gnee will Plan and as plan has lts of the t sists of te, sing, ntal linator and
	equipment, power, or emergencies; and nat	water failure; care-related ural disasters likely to safety of the participants,			•• • 17	1)	
	staff, or the public. The	ne policies and procedures I updated at least every 2					
				-	A marge		

Event ID:KN5N11

Facility ID: 475033

If continuation sheet Page 3 of 41

		ND HUMAN SERVICES		а.	FOF	ED: 08/03/202
STATEMENT	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>'</i>	PLE CONSTRUCTION	(X3) DAT	O 0938-039 E SURVEY IPLETED
		475033	B. WING		04	C 3/09/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		ACCIACE!
				312 CRESCENT BLVD		
CRESCEN	IT MANOR CARE CTRS			BENMINGTON, VT 05201		
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TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	
E 013	Continued From pag	e 3	E 0	TAG E 013 POC Accept	oted on 8/17/21	
	years.			by P.Cota		
		s at §494.62(b):] Policies and				
	and implement emer	lysis facility must develop gency preparedness policies				
		ed on the emergency plan n (a) of this section, risk				
		raph (a)(1) of this section,		<u>, 8</u>		
	and the communicati	on plan at paragraph (c) of				
		licies and procedures must				
		ated at least every 2 years.				
		nclude, but are not limited				
		power failures, care-related				
		supply interruption, and		1		
		ly to occur in the facility's				1
	geographicarea. This REQUIREMEN	is not met as evidenced		1		
	by:			249 243		1
	Based on staff interv	view and record review, the		3		
	facility failed to ensu					
		s and procedures are		. 1		
	reviewed and update include:	d at least annually. Findings				
	Per record review of	<b>e</b> ,				
		s and procedures, the		1 1		
	policies and procedu May 28th, 2019.	res were last updated on		ν <u>α</u>		
		e 9th, 2021 at approximately Administrator confirmed that				
		viewed or updated the		11		
	emergency prepared	ness policies and		(* <b>x</b> )		
	-	y of 2019 and that the facility		r vál		
<b>F</b> 00 1	is not in compliance	-				
E 034	Information on Occup	bancy/Needs	E 03	34		
SS=C	CFR(s): 483.73(c)(7)					
				1		
RM CMS-256	7(02-99) Previous Versions Ob:	solete Event ID;KN5N	11	Facility, ID: 475033	If continuation sh	eet Page 4 of 4

		ND HUMAN SERVICES			FORM	): 08/03/2021 APPROVED
		MEDICAID SERVICES	1		1	0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LETED
		475033	B. WING			C 09/2021
NAME OF P	ROVIDER OR SUPPLIER		1997	STREET ADDRESS, CITY, STATE, ZIP CODE		
CRESCEN	IT MANOR CARE CTRS			312 CRESCENT BLVD		
CRESCEN	I MANOR CARE CIRS			BEN INGTON, VT 05201	22	
(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 CORR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) Completion Date
E 034	<ul> <li>§441.184(c)(7), §482</li> <li>§483.73(c)(7), §483.4</li> <li>§485.68(c)(5), §485.6</li> <li>§485.625(c)(7), §485.6</li> <li>§494.62(c)(7).</li> <li>[(c) The [facility] must emergency prepared that complies with Fe and must be reviewed 2 years [annually for communication plan in following:</li> <li>(7) [(5) or (6)] A mean about the [facility's] of ability to provide assis having jurisdiction, th Center, or designee.</li> <li>*[For ASCs at 416.54 providing information its ability to provide a having jurisdiction, th Center, or designee.</li> <li>*[For Inpatient Hospid means of providing in hospice's inpatient of ability to provide assis having jurisdiction, th Center, or designee.</li> <li>*[For Inpatient Hospid means of providing in hospice's inpatient of ability to provide assis having jurisdiction, th Center, or designee.</li> <li>This REQUIREMENT by: Based on staff interv facility failed to includ</li> </ul>	<ul> <li>.54(c)(7), §418.113(c)(7)</li> <li>.15(c)(7), §460.84(c)(7),</li> <li>475(c)(7), §484.102(c)(6),</li> <li>58(c)(5), §485.727(c)(5),</li> <li>.920(c)(7), §491.12(c)(5),</li> <li>a develop and maintain an ness communication plan deral, State and local laws d and updated at least every LTC facilities]. The must include all of the</li> <li>ns of providing information ccupancy, needs, and its stance, to the authority e Incident Command</li> <li>(c)]: (7) A means of about the ASC's needs, and ssistance, to the authority e Incident Command</li> <li>ce at §418.113(c):] (7) A formation about the cupancy, needs, and its stance, to the authority e Incident Command</li> <li>ce at §418.113(c):] (7) A formation about the explancy, needs, and its stance, to the authority e Incident Command</li> <li>ce at §418.113(c):] (7) A formation about the explancy, needs, and its stance, to the authority e Incident Command</li> <li>ce at so the authority e Incident Command</li> <li>ce and record review, the e a means of providing facility's occupancy, needs, and its stance, to the authority e Incident Command</li> </ul>	E 034	<ol> <li>No residents were a practice.</li> <li>All residents have the by the deficient practi</li> <li>A comprehensive rev Emergency Preparedr on 7/6/21 by the Section 19: Notification Plan.</li> <li>The Administrator an educated on the need an emergency prepar plan that complies with laws that must be up (E034), and section Preparedness Plan Communication.</li> <li>The Administrator or Emergency Prepared quarterly for two quarterly for</li></ol>	e potential to b ce. view and upda ass plan was Administrator ons and Comm d Education N to develop and redness comm h Federal, State odated at leas 19 of the E : Notification designee will n edness Plan arters and as sure the E Commu n is updated ill present the API committee committee consi- his designee, of Nursing, nmental Servior rdinator and mpliance is ach	be affected ate of the completed including unications urse were d maintain unications e and local t annually cmergency ons and review the Manual necessary mergency nications/ at least ists of The Executive Infection ces, Social Dietary
EORM CMR 256	7(02-99) Previous Versions Obs	olete Event ID:KN5t	N13 E	acilily.)D: 475033	If continuation she	(H

CENTER STATEMENT C		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4750 33	(X2) MULTIPLE A. BUILDING _ B. WIN G		PRINTED: 08/03/2 FORM APPROV OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED C
			1		06/09/2021
	ROVIDER OR SUPPLIER		3	TREGT ADDRESS, CITY, STATE, ZIP COD 12 CRESCENT BLVD BENNINGTON, VT 05201	E
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIO
E 034	evidence that the faci providing information the facility's ability to required.	diction, the incident designee in the the emergency inication plan, there is no lity has a means of about occupancy, needs, or provide assistance as	E 034	TAG E 034 POC Accepte by P.Cota	ed on 8/17/21
E 035 SS=C	12:00 pm, the facility the facility is not in corregulation. LTC and ICF/IID Shar CFR(s): 483.73(c)(8) §483.73(c)(8); §483.4 *[For LTC Facilities at [(c) The LTC facility m an emergency prepar that complies with Fer and must be reviewed annually. The commu- all of the following:] *[For ICF/IIDs at §483 [(c) The ICF/IID must emergency prepared that complies with Fer and must be reviewed 2 years. The commu- all of the following:] (8) A method for shar	ing Plan with Patients 75(c)(8) §483.73(c):] sust develop and maintain edness communication plan deral, State and local laws d and updated at least unication plan must include	E 035	<ul> <li>deficient practice.</li> <li>2. All residents have by the alleged defice</li> <li>3. A letter was provide and/or family repro- the Emergency Pre- included bullet-poi sections of the plan standard mail. Inche notification that the Preparedness plan</li> <li>4. The Administrator and/or emails to fa to apprise them of a the emergency plan</li> <li>5. The Administrator, provided education Administrator on 7</li> <li>"LTC Sharing Plan w that a method for s the emergency plan and their families o annually (E035) is</li> </ul>	led to cognitive residents esentatives summarizing paredness Plan which ints highlighting the major via in-person delivery or uded in the letter is e complete Emergency is available for review. will send additional letter mily members as needed, any significant changes to h. and Education Nurse wer by the Regional /6/2021 regarding the with Patients" requiremen haring information from n with residents [or clients r representatives at least included in the Emergency
ORM CMS 255	7(02-99) Previous Versions Obs		1 5~	Preparedness Plan.	If continuation sheet Page 6 o

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED: 08/03/2021 FORM APPROVED OMB NO: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE SURVEY COMPLETED
	4750 33	B.WING	<u> </u>	C 06/09/2021
NAME OF PROVIDER OR SUPPLIER			STREAT ADDRESS, CITY, STATE, ZIP CODE	
		3	12 URESCENT BLVD	
CRESCENT MANOR CARE CT	RS	ļ E	BENMINGTON, VT 05201	1
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
families or repress This REQUIREME by: Based on staff int facility failed to ind information from t plan with resident representatives inPer record review preparedness con evidence that the information from t plan with residentPer record review preparedness con evidence that the information from t plan with residentPer interview on J 12:30 pm, the Nut facility is not in co EP Training and T CFR(s): 483.73(d)E 036 SS=CE 036 SS=CFor R(s): 483.73(d)§403.748(d), §446 §441.184(d), §460 §483.475(d), §484 §485.625(d), §485 §486.360(d), §491*[For RNCHIs at § Hospice at §418.1 at §460.84, Hospi §484.102, CORFs "Organizations" u §485.920, OPOs a §491.12:] (d) Trait must develop and preparedness trait	h residents [or clients] and their entatives. ENT is not met as evidenced terview and record review, the clude a method for sharing he emergency preparedness s and their families or the communication plan. of the emergency munication plan, there is no facility has a method for sharing he emergency preparedness s' families as required. une 9th, 2021 at approximately rese Educator confirmed that the mpliance with this regulation.	E 035	<ul> <li>6. The Regional Administrator audit the Emergency Preparence of the policy for a methin formation from the emerit of facility has determined with residents [or clients] or representatives is current two quarters and as neede</li> <li>7. The Administrator will protion and the audit to the QAPI commenter of the audit to the QAPI commenter of the Medical Director or his Executive Director, Director Infection Preventionist, Emservices, Social Worker, Medical Director and sustained.</li> <li>Responsible person: Administrator Completion date: 7/6/21</li> </ul>	aredness Plan to thod for sharing rgency plan, that l is appropriate, and their families ant quarterly for d. esent the results of nittee at least ittee consists of s designee, or of Nursing, wironmental DS Coordinator and e compliance is

Event ID:KN5N11

Facility (D: 475033

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		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE A. BUILDING _ B. WING	E CONSTRUCTION	PRINTED: 08/03/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C 06/09/2021
NAME OF P	ROVIDER OR SUPPLIER		s	STRI T ADDRESS, CITY, STATE, ZIP CODE	
CRESCEN	NT MANOR CARE CTRS		3	312 CRESCENT BLVD BEN∰NGTON, VT 05201	5 <sup>5</sup> 4
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETION
E 036	paragraph (a)(1) of the procedures at paragra the communication pl section. The training be reviewed and updat *[For LTC facilities at and testing. The LTC maintain an emergen and testing program to emergency plan set for section, risk assessment this section, policies at (b) of this section, and paragraph (c) of this set testing program must least annually. *[For ICF/IIDs at §483 testing. The ICF/IID na an emergency prepar program that is based forth in paragraph (a) assessment at paragraph (c) of this section, and the comm paragraph (c) of this set testing program must least every 2 years. T requirements for evac §483.470(i).	section, risk assessment at is section, policies and aph (b) of this section, and an at paragraph (c) of this and testing program must ated at least every 2 years. §483.73(d):] (d) Training facility must develop and cy preparedness training hat is based on the orth in paragraph (a) of this ent at paragraph (a)(1) of and procedures at paragraph d the communication plan at section. The training and be reviewed and updated at 8.475(d):] Training and nust develop and maintain edness training and testing 1 on the emergency plan set of this section, risk aph (a)(1) of this section, es at paragraph (b) of this nunication plan at section. The training and be reviewed and updated at he ICF/IID must meet the uation drills and training at at §494.62(d):] Training, n. The dialysis facility must an emergency , testing and patient	E 036	<ol> <li>All residents have the program the alleged deficient program was completed and program at least annual states and the emergency Prepared and the emergency Prepared and two quarters and as ensure the Emergence and two quarters and as ensure the Emergence and the emergen</li></ol>	potential to be affected by practice. view and update of the dness plan and testing eted on 7/6/21 by the ad education Nurse were egional Administrator on the requirement to review redness Plan and Testing ally. In designee will audit the tess Manual quarterly for necessary thereafter to by Preparedness Plan and been updated at least istrator will present the o the QAPI committee at API committee consists of or his designee, Executive of Nursing, Infection nmental Services, Social ator and Dietary Manager is achieved and sustained.

Facility ID: 475033

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If continuation sheet Page 8 of 41

CENTER STATEMENT		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ONISTRUCTION	PRINTED: 08/03/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
	OURIEDHON	475033	A. BUILDING	3	С
NAME OF P				REET ADDRESS, CITY, STATE, ZIP CODE	06/09/2021
	NT MANOR CARE CTRS		312	2 CRESCENT BLVD NNINGTON, VT 05201	
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E 036 E 039 SS=C	emergency plan set for section, risk assessment this section, policies a (b) of this section, and paragraph (c) of this section, and program is ready and program had not been 2019. Per interview on June 9:30 am, the facility A the facility has not ready program since May of not in compliance with EP Testing Requirement CFR(s): 483.73(d)(2) §416.54(d)(2), §448.1 §483.475(d)(2), §484.2 §483.475(d)(2), §485. §491.12(d)(2), §494.6 "[For ASCs at §416.5 "Organizations" under	orth in paragraph (a) of this rent at paragraph (a)(1) of and procedures at paragraph d the communication plan at section. The training, testing am must be evaluated and ears. I is not met as evidenced iew and record review, the e that the training and viewed and updated at least clude: the emergency g and testing program, the n updated since May of e 9th, 2021 at approximately administrator confirmed that viewed or updated the ness training and testing f 2019 and that the facility is n this regulation. ents 113(d)(2), §441.184(d)(2), 15(d)(2), §483.73(d)(2), .727(d)(2), §485.68(d)(2), .727(d)(2), §485.68, OPO, r §485.727, CMHCs at ICs at §491.12, and ESRD	E 036	TAG E 036 POC Accepte 8/17/21 by P.Cota	d on

Event ID:KN5N11

Facility ID: 475033

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES		(7)		PRINTED: 08/03/2021 FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES		ő		OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A, BUILDING			(X3) DATE SURVEY COMPLETED
		47503 3	B. WING			C 06/09/2021
NAME OF PI	ROVIDER OR SUPPLIER			STRE	TADDRESS, CITY, STATE, ZIP CODE	
				312 C 3	RESCENT BLVD	
CRESCEN	IT MANOR CARE CTRS		1		INGTON, VT 05201	
(X <b>4)</b> ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 039	to test the emergency must do all of the follo (i) Participate in a full community-based ever (A) When a communia accessible, conduct a exercise every 2 year (B) If the [facility] natural or man-made activation of the emer exempt from engaging community-based or i functional exercise fol actual event. (ii) Conduct an addition years, opposite the year functional exercise un this section is conduct not limited to the follor (A) A second full-scale community-based or i functional exercise; on (B) A mock disaster d (C) A tabletop exercise a facilitator and include a narrated, clinically-ri- scenario, and a set of directed messages, on designed to challenge (iii) Analyze the [facilitity]	ity] must conduct exercises y plan annually. The [facility] pwing: -scale exercise that is ery 2 years; or ity-based exercise is not a facility-based functional s; or experiences an actual emergency that requires gency plan, the [facility] is g in its next required ndividual, facility-based llowing the onset of the onal exercise at least every 2 ear the full-scale or nder paragraph (d)(2)(i) of ted, that may include, but is wing: e exercise that is ndividual, facility-based r rill; or e or workshop that is led by les a group discussion using elevant emergency problem statements, r prepared questions e an emergency plan. by's] response to and on of all drills, tabletop ency events, and revise the plan, as needed.	E 03	it it it it it it it it it it it it it i	<ol> <li>No residents were affected deficient practice.</li> <li>All residents have the poten by the alleged deficient practice.</li> <li>All residents have the poten by the alleged deficient prace.</li> <li>A facility table-top exert emergency plan was conduct.</li> <li>The Administrator, DON, an were educated by the Region on regarding the require exercises to test the emerget wice per year, including the drills using the emergency preparedness ptwo quarters and as nee ensure the facility is has conto test the emergency plan year, including unannounce the emergency procedures of the emergency procedures of requirements of E039. The present the results of the committee consists of The Main bis designed. Executive Division of the present the present the present the present present the present presen</li></ol>	ntial to be affected ctice. cise to test the cted on 7/7/2021. d Education Nurse onal Administrator ment to conduct ency plan at least inannounced staff procedures (E039). mee will audit the plan quarterly for ded thereafter to inducted exercises at least twice per ed staff drills using consistent with the Administrator will audit to the QAPI terly. The QAPI dedical Director or preventionist, cial Worker, MDS lanager to ensure
	IFUL HUSPICES At 418					
FORM CMS-256	7(02-99) Previous Versions Obso	blete Event ID:KN5M	111 F	acility, ID	); 475033 If continu	ation sheet Page 10 of 41

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		ND HUMAN SERVICES		Ă	FORM	0: 08/03/2021 APPROVED 0.0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING			LETED
		475033	B. WING	3 	1	C 09/2021
NAME OF P	ROVIDER OR SUPPLIER			STREAT ADDRESS, CITY, STATE, ZIP CODE		
CRESCE	NT MANOR CARE CTRS			312 GRESCENT BLVD BEN위INGTON, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
E 039	<ul> <li>(2) Testing for hospic patient's home. The exercises to test the annually. The hospic (i) Participate in a ful community based evere (A) When a community accessible, conduct a functional exercise everes (B) If the hospice expireman-made emergency plan, engaging in its next recommunity-based function onset of the emergen plan, engaging in its next recommunity-based function onset of the emergen (ii) Conduct an additi opposite the year the exercise under paragi is conducted, that mat to the following:</li> <li>(A) A second full-sca community-based or exercise; or</li> <li>(B) A mock disaster of (C) A tabletop exercia a facilitator and include a narrated, clinically-riscenario, and a set of directed messages, or designed to challenge</li> <li>(3) Testing for hospice the exercises to test the exercise to test the exercises to test the exercises to test the exercises to test the exercise to test the exercises to test the exercise to test the exercises to test the exercise</li></ul>	the spice must conduct emergency plan at least the must do the following: I-scale exercise that is ery 2 years; or ty based exercise is not in individual facility based very 2 years; or eriences a natural or by that requires activation of the hospital is exempt from equired full scale ercise or individual hal exercise following the cy event. onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section by include, but is not limited le exercise that is a facility based functional drill; or se or workshop that is led by des a group discussion using relevant emergency f problem statements, r prepared questions e an emergency plan. es that provide inpatient spice must conduct emergency plan twice per ust do the following: nnual full-scale exercise that	E 039	TAG E 039 POC Accepted on a by P.Cota	8/17/21	

Event ID:KN5N11

Facility ID: 475033

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				FC	red: 08/03/2021 0RM APPROVED NO: 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) D	ATE SURVEY DMPLETED
	475033	B. WING	۵ 		C 06/09/2021
ROVIDER OR SUPPLIER	L		STRE OT ADDRESS, CITY, STATE,		
IT MANOR CARE CTRS				199 S. 11	
(EACH DEFICIENC	YMUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE	(X5) COMPLETION DATE
<ul> <li>(A) When a communitation of the energy of the energy plan, engaging in its next metabased or facility-based or exercise; or</li> <li>(B) A mock disaster of (C) A tabletop exercification that include narrated, clinically-reliand a set of problem messages, or prepare challenge an emerge (iii) Analyze the hosp maintain documentatiexercises, and emerge</li> </ul>	ity-based exercise is not an annual individual nal exercise; or beriences a natural or by that requires activation of the hospice is exempt from equired full-scale community ed functional exercise f the emergency event. ional annual exercise that of limited to the following: ale exercise that is a facility based functional drill; or ise or workshop led by a es a group discussion using a levant emergency scenario, statements, directed ed questions designed to ency plan. bice's response to and ion of all drills, tabletop gency events and revise the	E 039	11 - 194 - 153 - 153		
§482.15(d), CAHs at (2) Testing. The [PRT conduct exercises to twice per year. The [ do the following: (i) Participate in an a is community-based;	§485.625(d):] F, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must innual full-scale exercise that or			55	5
	S FOR MEDICARE & OF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER T MANOR CARE CTRS SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page (A) When a communiaccessible, conduct a facility-based function (B) If the hospice exp man-made emergency the emergency plan, engaging in its next r based or facility-based following the onset of (ii) Conduct an addit may include, but is ne (A) A second full-sca community-based or exercise; or (B) A mock disaster (C) A tabletop exerci- facilitator that include narrated, clinically-re and a set of problem messages, or prepare challenge an emerge (iii) Analyze the hosp maintain documentat exercises, and emerge (iii) Analyze the hosp maintain documentat exercises and emerge (iii) Analyze the hosp maintain documentat exercises to twice per year. The [PRT conduct exercises to twice per year. The [ do the following: (i) Participate in an a is community-based;	CORRECTION       IDENTIFICATION NUMBER:         475033         ROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 11         (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or         (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.         (ii) Conduct an additional annual exercise that may include, but is not limited to the following:         (A) A second full-scale exercise that is community-based or a facility based functional exercise; or         (B) A mock disaster drill; or         (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion 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 hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.         *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]       (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan	SFOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLI A BUILDING.         CONDER OR SUPPLIER       475033       B. WING	SFOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES         OF DEFICIENCIES         CORRECTION         IDENTIFICATION NUMBER:         ABULDING         475033         ROVIDER OR SUPPLIER         IT MANOR CARE CTRS         SUMMARY STATEMENT OF DEFICIENCIES         Continued From page 11         (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or         (B) If the hospice experiences a natural or man-made emergency plan, the hospice is exempt from engaging in its next required full-scale community based or a facility based functional exercise is not accessible, conduct an additional annual exercise that is community-based or a facility based functional exercise is or (B) A mock disaster drill; or         (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion 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 hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency plan. (ii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises or or stand revise the hospice's emergency plan. (CAH] must cond	MENT OF HEALTH AND HUMAN SERVICES OMB SFOR MEDICARE & MEDICAID SERVICES OMB OBENCIENCE: STRUCT ADDRESS, CR1, FRAVDERSUPPLIKICLA DEMTIFICATION NUMBER. 475033 B. WING 475033 B. WING A BULDING 475033 B. WING A BULDING A BULDIS NOT INFORMATION A BULDING A BULDING

Event ID:KN5N11

Facility ID: 475033

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#### PRINTED: 08/03/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 475033 B. WING 06/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 312 GRESCENT BLVD CRESCENT MANOR CARE CTRS BENMINGTON, VT 05201 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIONSHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 4 E 039 Continued From page 12 E 039 (B) If the [PRTF, Hospital, CAH] experiences an 3 actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared ľ 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 PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or .... man-made emergency that requires activation of 1

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

Facility (D: 475033

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

**IDENTIFICATION NUMBER:** 

475033

STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

FORM APPROVED OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING С

PRINTED: 08/03/2021

06/09/2021

### B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1

			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) COMPLETIC DATE		
E 039	Continued From page 13	E 039	1 <u>85</u> - 41				
2 000	the emergency plan, the PACE is exempt from		48				
	engaging in its next required full-scale community		- di				
	based or individual, facility-based functional						
	exercise following the onset of the emergency	1	1				
	event.	1					
	(ii) Conduct an additional exercise every 2		1.00				
	years opposite the year the full-scale or functional						
	exercise under paragraph (d)(2)(i) of this section						
	is conducted that may include, but is not limited to						
	the following:						
	(A) A second full-scale exercise that is						
	community-based or individual, a facility based						
	functional exercise; or	1	1				
	(B) A mock disaster drill; or		i ar				
	(C) A tabletop exercise or workshop that is led by						
	a facilitator and includes a group discussion,		1.12				
	using a narrated, clinically-relevant emergency		1				
	scenario, and a set of problem statements,						
	directed messages, or prepared questions		12				
	designed to challenge an emergency plan.						
	(iii) Analyze the PACE's response to and						
	maintain documentation of all drills, tabletop						
	exercises, and emergency events and revise the		6.13				
	PACE's emergency plan, as needed.						
	*[For LTC Facilities at §483.73(d):]				1		
	(2) The [LTC facility] must conduct exercises to		3				
	test the emergency plan at least twice per year,		- 2.46				
	including unannounced staff drills using the						
	emergency procedures. The [LTC facility,		1.8				
	ICF/IID] must do the following:						
	(i) Participate in an annual full-scale exercise that		1.1				
	is community-based; or		1.1				
	(A) When a community-based exercise is not		1.01				
	accessible, conduct an annual individual,		1999				
	facility-based functional exercise.						
	(B) If the [LTC facility] facility experiences an		10				
	actual natural or man-made emergency that		1.24				
					1		

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

Event ID:KN5N11

Facility ID: 475033

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					D: 08/03/2021	
		MEDICAID SERVICES		3	x.		0.0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	17	NSTRUCTION	(X3) DATE		
		475033	B. WING		5.	1	C /09/2021	
NAME OF P	ROVIDER OR SUPPLIER		- <u>-</u>	STRL	TADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2021	
			312 (RESCENT BLVD					
CRESCEN	IT MANOR CARE CTRS		BENMINGTON, VT 05201					
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	J	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	8	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	Drife	
			-	_		-Weilde	185.	
E 039	Continued From page	a 1 <i>4</i>	EO					
L 000				128				
		the emergency plan, the from engaging its next		- 10	Ĵ			
	required a full-scale of							
		ed functional exercise						
		the emergency event.						
		onal annual exercise that			-			
		ot limited to the following:		- 35	1			
	(A) A second full-sca	le exercise that is						
	· ·	an individual, facility based						
	functional exercise; o							
	(B) A mock disaster							
		se or workshop that is led by						
		a group discussion, using a		30	*			
	and a set of problem	levant emergency scenario, statements_directed						
		ed questions designed to			50.			
	challenge an emerge			1	12 =2			
		facility] facility's response to		6	* 5			
		ntation of all drills, tabletop		3				
		ency events, and revise the						
	[LTC facility] facility's	emergency plan, as needed.			ł			
		2 4767 13			•0			
	*[For ICF/IIDs at §48:	3.475(d)]: ID must conduct exercises						
		<i>i p</i> lan at least twice per year.			ł.			
	The ICF/IID must do			13	- 2/			
		nnual full-scale exercise that		1	1			
	is community-based;							
	(A) When a communi	ty-based exercise is not		- 2				
	accessible, conduct a							
	facility-based function							
		eriences an actual natural or						
	-	y that requires activation of			1			
	engaging in its next re	the ICF/IID is exempt from						
		ndividual, facility-based			5. 10			
1		llowing the onset of the						
	emergency event.				1		5	
	<b>U ( )</b>				ł			
ORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID:KN5N		Encility 3	2): 475033 If coolin	untion shop	1 Page 15 of 41	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES		10			1 APPROVE 0.0938-039
TATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING			(X3) DATE COMP	SURVEY LETED
		47503 3	B. WING	2			C 09/22021
NAME OF P	ROVIDER OR SUPPLIER	1	5	TRE	ADDRESS, CITY, STATE, ZIP CODE	•	
CRESCEN	IT MANOR CARE CTRS				ESCENT BLVD NGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL &SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) Completion Date
E 039	Continued From page	e 15	E 039				
		onal annual exercise that					
		ot limited to the following:					
	(A) A second full-sca	5		3			
		an individual, facility-based				1	
	functional exercise; o	or		- 64			
	(B) A mock disaster of			- 8			
		se or workshop that is led by		- 8			
		des a group discussion,		- ä			
		ically-relevant emergency		5353		9	
		f problem statements,		2.0			
	-	or prepared questions e an emergency plan.					
		ID's response to and	1 I				
		ion of all drills, tabletop		- 32			
		gency events, and revise the		1			
	ICF/IID's emergency						
	*[For HHAs at §484.7	1021					
		HA must conduct exercises		10101			
	to test the emergence			3			
1		HA must do the following:		4			
	(i) Participate in a ful	I-scale exercise that is		- 34		1	
	community-based; or						
		munity-based exercise is not		1.2			
	accessible, conduct a		1				
	facility-based function	nal exercise every 2 years;		- 24			
	or.			1.12			
		xperiences an actual natural					
	•	ency that requires activation					
		n, the HHA is exempt from					
	engaging in its next r	equired full-scale individual, facility based					
		Nowing the onset of the					
	emergency event.			1			
		onal exercise every 2 years,		235			
	opposite the year the			- U			
		raph (d)(2)(i) of this section					
		at may include, but is not		.1			
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		ID HUMAN SERVICES MEDICAID SERVICES							FOR	D: 08/03/2021 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		ONSTRUC		5 x	2.0	(X3) DATE COM	E SURVEY PLETED
		475033	B.WING							C /09/22021
NAME OF P	ROVIDER OR SUPPLIER	<b>.</b>	1	STF	RETADD	RESS, CITY	, state, zip (	CODE		
CRESCEN	T MANOR CARE CTRS			312	GRESCE	ENT BLVD	e.			
ONLOOLI				BE	NMINGT	ON, VT 0	<b>520</b> 1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG			(EACH COR	RECTIVE AC	CORRECTION TION SHOULD THE APPROPP CY)	BE	(X5) COMPLETION DATE
E 039	Continued From page limited to the following		E 03	39	4 11 1					
		e. -scale exercise that is			- 1					
		an individual, facility-based								
	functional exercise; o									
	(B) A mock disas				4					
	led by a facilitator and	ercise or workshop that is			4					
		arrated, clinically-relevant			1					
	emergency scenario,	-			24					
		messages, or prepared								
	questions designed to plan.	o challenge an emergency			1					
	•	s response to and maintain								
		drills, tabletop exercises, and			3					
	emergency events, ar emergency plan, as n									
	*[For OPOs at §486.3	601								
		PO must conduct exercises			3					
		plan. The OPO must do the								
	following:	and tableton evening or			6 <b>1</b> 5					
		ased, tabletop exercise or nually. A tabletop exercise is t includes a group			ε.e.					
		arrated, clinically relevant			580 54					
	emergency scenario,	and a set of problem			10					
		messages, or prepared			1					
		challenge an emergency			R.					
		riences an actual natural or y that requires activation of								
		the OPO is exempt from			ě.					
		equired testing exercise			035					
	5	the emergency event.			4					
		s response to and maintain abletop exercises, and			231					
		nd revise the [RNHCI's and			10 1					
	OPO's] emergency pla									3
					a.					

Event ID:KN5N11 Facility iD: 475033

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/03/2021 FORM APPROVED

		MEDICAID SERVICES	1		1	0 <u>, 0938-039'</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED C
		475033	B, WING		06	C 5/09/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	+ )(=;
CRESCEN	NT MANOR CARE CTRS			312 CRESCENT BLVD BENRINGTON, VT 05201	<b>4</b> 2%	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
E 039	*[ RNCHIs at §403.74 (d)(2) Testing. The R exercises to test the must do the following (i) Conduct a paper-to least annually. A table discussion led by a fa- clinically-relevant error of problem statement prepared questions of emergency plan. (ii) Analyze the RNH4 maintain documentation and emergency event emergency plan, as in This REQUIREMENT by: Based on staff intervi- facility failed to condu- emergency plan at let Per review of the em- exercise records for had no record of con- exercise as required. Per interview on June 12:00 pm, the facility the facility had not co- exercise to test the e- plan during the year a not in compliance with INITIAL COMMENTS.	<ul> <li>48]:</li> <li>NHCI must conduct emergency plan. The RNHCI emergency plan. The RNHCI emergency scenario, and a set etop exercise is a group acilitator, using a narrated, ergency scenario, and a set is, directed messages, or lesigned to challenge an</li> <li>CI's response to and ion of all tabletop exercises, is, and revise the RNHCI's needed.</li> <li>T is not met as evidenced</li> <li>T is</li></ul>	FO	39		
	-	-				

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

Event ID:KN5N11

Facility ID: 475033

 If continuation sheet Page 18 of 41

STATEMENT	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE		OMB NO, 0938-039 (X3) DATE SURVEY COMPLETED
		475033	B. WING		C 06/09/2021
	ROVIDER OR SUPPLIER	L	31	RET ADDRESS, CITY, STATE, ZIP C 2 CHESCENT BLVD ENTIMOTON, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETIO THE APPROPRIATE DATE
	without corresponding care. The jeopardy w of exit, but the facility immediate corrective agency since the sur- regulatory deficiencies the recertification sur Develop/Implement C CFR(s): 483.21(b)(1)	g substandard quality of as not removed at the time has submitted an action plan to the survey vey exit date. The following as were cited as a result of vey: comprehensive Care Plan	F 000 F 656		he alleged deficient practice: Iurse/designee initiated a car ne risks associated wit
	implement a compreh care plan for each re- resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The com describe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483. provided due to the re- under §483.10, include treatment under §483 (iii) Any specialized s rehabilitative services provide as a result of recommendations. If findings of the PASAF	cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's I mental and psychosocial ied in the comprehensive mprehensive care plan must g- are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). ervices or specialized as the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the		On 6/8/2021 The Reg initiated a care plan for res for resident #56. Ch 6/8/2021 The MDS care plan for resident #1 alarm. Residents with the po alleged deficient practices The DON/designee audit to review/revise resident it tegrity, elopement,	nurse/designee initiated a skin sident #64. gistered Dietician/ designed address the nutritional statu 5 nurse/designee revised the 7 to remove the Wanderguard otential to be affected by the

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CENTER					FORM APPR
	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		OMB NO. 0938 (X3) DATE SURVEY COMPLETED
		47503 3	B. WING	<u> </u>	C 06/09/202
NAME OF P	ROVIDER OR SUPPLIER		s.	TREAT ADDRESS, CITY, STATE, ZIP CODE	
CRESCE	NT MANOR CARE CTRS			12 G RESCENT BLVD REN LINGTON, VT 0 520 1	, ; ;
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPL
F 656	<ul> <li>desired outcomes.</li> <li>(B) The resident's profuture discharge. Factors whether the resident's community was assee local contact agencies entities, for this purper (C) Discharge plans in plan, as appropriate, requirements set fort section.</li> <li>This REQUIREMENT by:</li> <li>Based on observation review, the facility fait comprehensive care residents (Residents include:</li> <li>1. Per review of the coplan of care to addree related to skin integrit admitted in Septemb self-inflicted scratcher review indicates this throughout the admiss to address potential finor is there a care plawounds. On 06/09/21 Manager confirmed to shin integrity nor to since admission. The</li> </ul>	als for admission and eference and potential for cilities must document is desire to return to the ssed and any referrals to es and/or other appropriate ose. In the comprehensive care in accordance with the h in paragraph (c) of this If is not met as evidenced on, staff interview and record led to develop a plan for 4 of 22 applicable # 28, 56, 64, 17). Findings	F 656	<ul> <li>Measures/ Systemic Change: On 7/8/2021, The Director of N Interdisciplinary team on initial and/or revising care plans rout residents' current status.</li> <li>On 7/8/2021, The Nurse Educat lurses will educate began educ taff on initiating, reviewing an plans routinely to reflect the resident's condition/status.</li> <li>The Nurse Educator or DON will existing policies in order to ensident's condition/status.</li> <li>Hew clinical staff will be educate orocess in orientation.</li> <li>Monitor Corrective Actions On 7/13/2021 The MDS Nurse, O resident records, including representation.</li> <li>Monitor Corrective Actions On 7/13/2021 The MDS Nurse, O resident records, including representation.</li> <li>Monitor compliance is achies and given to the DON on a montorrection.</li> <li>Ance 100% compliance is achies and given to the DON on a montorrection.</li> <li>Ance 100% compliance is achies and given to the DON on a montorrection.</li> <li>Ance 100% compliance is achies and given to the DON on a montorrection.</li> <li>Ance 100% compliance is achies and given to the DON on a montorrection.</li> <li>Ance 100% compliance is achies and given to the DON on a montorrection.</li> <li>Ance 100% compliance is achies and given to the DON on a montorrection.</li> <li>Ance 100% compliance is achies and given to the DON on a montorrection.</li> <li>Ance 100% compliance is achies and given to the DON on a montorrection.</li> <li>And then randomly thereafter</li> <li>And then randomly thereafter<!--</td--><td>ting, reviewing inely to reflect the tor or Director of ating the nursing d/or revising care sidents' current I review/revise ure care plans refle red on the care plan dew admissions, to ess of the CCP on a swill be document thy basis for ved, the MDS Nurs ord reviews a mon er. results of the audi- f The Medical tive Director, Director ist, Environmenta pordinator and pliance is achieved</td></li></ul>	ting, reviewing inely to reflect the tor or Director of ating the nursing d/or revising care sidents' current I review/revise ure care plans refle red on the care plan dew admissions, to ess of the CCP on a swill be document thy basis for ved, the MDS Nurs ord reviews a mon er. results of the audi- f The Medical tive Director, Director ist, Environmenta pordinator and pliance is achieved

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CO A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C
	ROVIDER OR SUPPLIER	415033		T ADDRESS, CITY, STATE, ZIP COL	06/09/2021
				RESCENT BLVD	137
	IT MANOR CARE CTRS			MINGTON, VT 05201	<i>.</i> /%
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIO E APPROPRIATE DATE
F 656	7/10/2019, Resident a high risk for elopeme intervention was add that states, "Wanderd when a resident cross placed on left wrist for intervention was revis care plan. Per observation on 6 #17 was not observe either wrist. This was interview on 6/8/2027 observing Resident # RN stated they do no wander alarm on Res he/she could rememi Per interview on 6/8/2 Memory Unit Coordin recall seeing a wand as long as they have is approximately one Coordinator confirme being implemented a the care plan. 3. Per record review, Physicians order for anticoagulant medica from clotting) 5.5 mg irregular and often ra increase the risk of	is (leaving the facility without staff knowledge). On #17 was care planned for nt. On 8/4/2020 an ed for this care plan focus Guard [a device that alarms ses a certain boundary] or [his/her] safety." This sed on 5/25/2021 per the /8/2021 at 2:45 pm, Resident d to have any device on 6 confirmed by an RN per 1 at 2:45pm who was #17 at the same time. The t remember seeing a sident #17 as far back as ber. 2021 at 3:00 pm, the lator stated that they don't er alarm on Resident #17 for worked at the facility, which month. The Memory Unit d that this intervention is not nd should be removed from Resident # 28 has a Warfarin Sodium (an ition used to prevent blood daily for atrial fibrillation (an pid heart rate that can eveloping blood clots). ot have a care plan in place se of, nor the risks	F 656	TAG F 656 POC Accep 8/17/21 by P.Cota	oted on
		n 06/09/2021 at 2:07 PM the onfirmed that Resident #28's			
M CMS-256	7(02-99) Previous Versions Ob		J11 Escility	k): 475033	If continuation sheet Page 21 of

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STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       4 703 3         4 703 3         NAME OF PROVIDER OR SUPPLIER         CRESCENT MANOR CARE CTRS         (X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         (X4) ID         PREFIX         CRESCENT MANOR CARE CTRS         (X4) ID         PREFIX         TAG         SUMMARY STATEMENT OF DEFICIENCIES         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         REGULATORY OR LSC IDENTIFYING INFORMATION)         F 656         Continued From page 21         care plan should address the use of         anticoagulation therapy.         4. Per record review, there is no care plan to to         address Resident #56's ongoing weight loss. The         resident has the following diagnoses: Dysphagia,         Oropharyngeal Phase; Dementia without         behavioral disturbance; Noninfective         Gastroenteritis and Colitis, Unspecified; Major	(X2) MULTI A. BUILDING B. WING B. WING PREFIX TAG	IG STRE 312 ( BEN		ATE SURVEY MPLETED C D6/09/2021 (X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER         CRESCENT MANOR CARE CTRS         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         F 656       Continued From page 21 care plan should address the use of anticoagulation therapy.         4.       Per record review, there is no care plan to to address Resident #56's ongoing weight loss. The resident has the following diagnoses: Dysphagia, Oropharyngeal Phase; Dementia without behavioral disturbance; Noninfective	ID PREFIX TAG	312 ( BEN	LT ADDRESS, CITY, STATE, ZIP CODE CRESCENT BLVD WINGTON, VT 05201 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	06/09/2021 (X5) COMPLETION
CRESCENT MANOR CARE CTRS         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         F 656       Continued From page 21 care plan should address the use of anticoagulation therapy.         4. Per record review, there is no care plan to to address Resident #56's ongoing weight loss. The resident has the following diagnoses: Dysphagia, Oropharyngeal Phase; Dementia without behavioral disturbance; Noninfective	PREFIX TAG	312 ( BEN	RESCENT BLVD	COMPLETION
(X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         F 656       Continued From page 21 care plan should address the use of anticoagulation therapy.         4. Per record review, there is no care plan to to address Resident #56's ongoing weight loss. The resident has the following diagnoses: Dysphagia, Oropharyngeal Phase; Dementia without behavioral disturbance; Noninfective	PREFIX TAG	BEN	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         F 656       Continued From page 21 care plan should address the use of anticoagulation therapy.         4. Per record review, there is no care plan to to address Resident #56's ongoing weight loss. The resident has the following diagnoses: Dysphagia, Oropharyngeal Phase; Dementia without behavioral disturbance; Noninfective	PREFIX TAG		EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
<ul> <li>care plan should address the use of anticoagulation therapy.</li> <li>4. Per record review, there is no care plan to to address Resident #56's ongoing weight loss. The resident has the following diagnoses: Dysphagia, Oropharyngeal Phase; Dementia without behavioral disturbance; Noninfective</li> </ul>	F 6			
<ul> <li>care plan should address the use of anticoagulation therapy.</li> <li>4. Per record review, there is no care plan to to address Resident #56's ongoing weight loss. The resident has the following diagnoses: Dysphagia, Oropharyngeal Phase; Dementia without behavioral disturbance; Noninfective</li> </ul>				
<ul> <li>anticoagulation therapy.</li> <li>4. Per record review, there is no care plan to to address Resident #56's ongoing weight loss. The resident has the following diagnoses: Dysphagia, Oropharyngeal Phase; Dementia without behavioral disturbance; Noninfective</li> </ul>				
4. Per record review, there is no care plan to to address Resident #56's ongoing weight loss. The resident has the following diagnoses: Dysphagia, Oropharyngeal Phase; Dementia without behavioral disturbance; Noninfective				
address Resident #56's ongoing weight loss. The resident has the following diagnoses: Dysphagia, Oropharyngeal Phase; Dementia without behavioral disturbance; Noninfective				
Oropharyngeal Phase; Dementia without behavioral disturbance; Noninfective				
behavioral disturbance; Noninfective				
				1
Gastroententis and Collits, Unspecified; Major			3	1
Depressive Disorder, Recurrent, unspecified.			.)	
The resident lost 18.5 pounds, which is 15.23% of			1	
her/his body weight within the previous 90 days.				1
On 2/11/21 her/his weight was 121.5 and on			Ϋ́ κ	
5/13/21 her/his weight was documented as 103.0.				
She/he is significantly below her/his IBW (Ideal				
Body Weight), per a dietician assessment that			3 100	
revealed her/his BMI to be 18.8 and her/his IBW			- L -	
is documented as being between 131 and 159 pounds.			2	
pounds.				
An annual FCC2 Mini Nutritional Assessment was			-1	
completed on 4/5/21 and the dietician scored the				
resident at an 8.0. The legend at the bottom of				
this assessment revealed that an 8.0 mean at risk			7	
of malnutrition. At the time of this assessment			- E 1 #	
the residents weight is documented as being				
115.9 pounds, moderate decrease in food intake, weight loss between 1 and 3 kg (2.2 pounds to			1	
6.6 pounds), the resident has severe dementia or			- 4	
depression, and the residents BMI is 21 to less				
than 23.			2. 1	
On 5/6 the FCC2 Mini Nutritional Assessent was			1	
completed as a quarterly assessment and scored			1	
as a 3.0. The legend at the bottom of this				
assessment revealed that an 3.0 means the				
resident is malnourished. At the time of this assessment the residents weight is documented			81 5	
as being 105.4 pounds, severe decrease in food				
intake, weight loss greater than 3 kg (6.6				

Facility.(1): 475033

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES		Í.		PF	RINTED: 08/03/2021 FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				D	MB NO: 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A- BUILDIN		STRUCTION		3) DATE SURVEY COMPLETED
		475033	B. WING_	7			C 06/09/2021
NAME OF P	ROVIDER OR SUPPLIER	1		STREET	ADDRESS, CITY, STATE, ZIP C		00/05/2021
					ESCENT BLVD		
CRESCEN	IT MANOR CARE CTRS				NGTON, VT 05201	4	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETION DATE
F 656	Continued From page	22	F 6	56			
		entia or depression and a					
	"Eating: Assistance of to dine at meal. I have prefer to be fed. I red dine." This piece of t updated on 3/23/21. Nursing Rehab/Restor "Eating/Swallowing P safety and independe Encourage out-of-beo Dining Room whe ope all foods into bite-size for tray and place with	rogram #1 to maximize		A share of the second			
	ground meat and pota clear residue. 5) Prov meals as tolerated 6.) toast as an alternative part of the care plan v Interview on 6/8/21 at	atoes) and/or solid/liquids to vide 1:1 assistance with ) Provide pureed French e if I refuse my meal." This was last updated on 4/15/21. t approximately 1:30 PM, ealed that she/he was aware					
	of this residents weig that the resident requ her/him for all meals.	ht loss and that staff know ires someone to feed The dietician confirmed ompleted a care plan to		international (see ) international (see )			
F 692 SS=G	Nutrition/Hydration St CFR(s): 483.25(g)(1)		F 6	92			
	(Includes naso-gastri both percutaneous er	nutrition and hydration. c and gastrostomy tubes, ndoscopic gastrostomy and popic jejunostomy, and d on a resident's		1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1			
OPM CMS 256	7(02-99) Previous Versions Obs	olete Event ID:KN5N		Facility 1/2:	475033	If continuatio	on sheet Page 23 of 41

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		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MUL A. BUILD B. WING	ING		FORM OMB NC (X3) DATE COMF	D: 08/03/202 <sup>7</sup> MAPPROVEE <u>).0938-0391</u> SURVEY PLETED C <b>09/2021</b>
	ROVIDER OR SUPPLIER	<b>L</b>		31:	REAT ADDRESS, CITY, STATE, ZIP CODE 2 GRESCENT BLVD ENMINGTON, VT. 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	ensure that a residem §483.25(g)(1) Maintai of nutritional status, s desirable body weigh balance, unless the re- demonstrates that this preferences indicate of §483.25(g)(2) Is offer maintain proper hydra §483.25(g)(3) Is offer there is a nutritional p provider orders a ther This REQUIREMENT by: Based on interview a determined that the fa acceptable nutritional and who had significat residents in the surve Findings include: Review of the electron revealed that Reside facility in June 2020. significant avoidable of facility. The resident Dysphagia, Oropharyn without behavioral dis Gastroenteritis and C Depressive Disorder, The resident lost 18.5 her/his body weight w 2/11/21 her/his weight her/his weight was do	essment, the facility must t- ins acceptable parameters uch as usual body weight or trange and electrolyte esident's clinical condition is is not possible or resident otherwise; ed sufficient fluid intake to ation and health; ed a therapeutic diet when problem and the health care rapeutic diet. is not met as evidenced and record review, it was acility failed to maintain supports to residents at risk acility failed to maintain supports to residents at risk int weight loss for 1 of 20 y sample (Resident #56). hic medical record (EMR), nt #56 was admitted to the The resident has had a weight loss while in the has the following diagnoses: ngeal Phase; Dementia turbance; Noninfective olitis, Unspecified; Major Recurrent, unspecified. ip pounds, which is 15.23% of ithin a 90 day period. On t was 121.5 and on 5/13/21	F	692	Residents affected by the alleged Cn 6/8/2021 The registered Dietic Priviewed the resident #56 's medi and revised a nutritional support a address the resident's weight loss. 2 Potential for Those Residents residents with a compromised nut potential to be affected by the practice. On 7/7/21 Dietician/designee reviewed resid high risk for weight loss to ensur- place to effectively deal and/or practice of the regional Nurse Consultant and N with the dietician to discuss the specific the position, including but Accurately monitoring and trackin providing intervention to pre- residents to assure appra- ate in place to reflect the resident's atus weekly x4 then monthly thereafter. The dietician will presen- audit to the QAPI committee at least committee consists of The Medic designee, Executive Director, Di- Infection Preventionist, Environmer Worker, MDS Coordinator and I ensure compliance is achieved and s Presention Date: 7/13/21	cian/desig calrecord and care p to be Aff ritional in s alleged The F ents at mo e there is comote we tus. On 7/7/2 urse Educe cific resp not lir g residen vent wei ignee will may inclu opriate int s current is x3 then at the resu monthly. cal Direct rector of tal Servic Dietary M	gnee l, review olan to fected: All itake have deficient Registered oderate to a plan in eight gain 2021, The cator met oonsibility nited to: t weights, ght loss, l begin to ide newly erventions nutritional randomly ults of the The QAPI for or his Nursing, ces, Social

Event ID:KN5N11

Facility (D: 475033

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If continuation sheet Page 24 of 41

		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING		PRINTED: 08/03/202 FORM APPROVED OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		475033	B. WING		C 06/09/2021
NAME OF P	ROVIDER OR SUPPLIER		ST	RINT ADDRESS, CITY, STATE, ZIP CODE	
CRESCEN	NT MANOR CARE CTRS	z.		2 GRESCENT BLVD ENNINGTON, VT 05201	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL. .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 692	Body Weight), per a c revealed her/his BMI is documented as bei pounds. An annual FCC2 Mini completed on 4/5/21a resident at an 8.0. Th	lietician assessment that to be 18.8 and her/his IBW ng between 131 and 159 Nutritional Assessment was nd the dietician scored the he legend at the bottom of	F 692	TAG F 692 POC Accepted by P.Cota	l on 8/17/21
	risk of malnutrition. A assessment the resid as being 115.9 pound food intake, weight lo pounds to 6.6 pounds	aled that an 8.0 means at t the time of this ents weight is documented s, moderate decrease in ss between 1 and 3 kg (2.2 ), the resident has severe on, and the residents BMI is			12
	was completed as a c scored as a 3.0. The assessment revealed resident is malnourish assessment the resid as being 105.4 pound intake, weight loss gre	entia or depression and a			
	"Eating: Assistance w to dine at meal. I hav prefer to be fed. I req dine." This piece of the updated on 3/23/21. Nursing Rehab/Resto "Eating/Swallowing Prisafety and independe Encourage out-of-bed	ogram #1 to maximize			
IRM CMS-256	7(02-99) Previous Versions Obse	olete Event ID:KN5N	I11 Facil	ity 10: 475033 [f	continuation sheet Page 25 of 47

CENTER		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		, F CC	I	FOR OMB N	D: 08/03/20 M APPROV <u>O. 0938-03</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
		475033	B. WING		<u>}</u>	06	5/09/2021
AME OF PR	ROVIDER OR SUPPLIER			STRI	T ADDRESS, CITY, STATE, ZIP CODE		
RESCEN	IT MANOR CARE CTRS				RESCENT BLVD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 692	all foods into bite-size for tray and place with 4) Monitor for pocketing ground meat and pota clear residue. 5) Provi- meals as tolerated 6. toast as an alternative part of the care plan with the dietician, rev- of this residents weig that the resident requi- her/him for all meals. that she/he has not care	e pieces. 3) Remove items nin [Resident #56's] reach. ng. Alternate textures (e.g., atoes) and/or solid/liquids to ide 1:1 assistance with Provide pureed French e if I refuse my meal." This was last updated on 4/15/21. t approximately 1:30 PM, ealed that she/he was aware ht loss and that staff know ires someone to feed The dietician confirmed ompleted a care plan to	F 69:		Residents affected by the alleged	deficient p	ractice:
	address this residents weight loss and didn't realize she/he needed to do a seperate care plan for weight loss. See also F656. Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.		F 756	7 14 2 2 0 0 2 2 0 0 2 2 1 1 1 1 1 1 1 1 1 1	Besident #27 was not affected by the MD immediately reviewed and gimen. Potential for residents to be afficient practice: Il residents who receive as needed we the potential to be affected by actice. The DON will ensure no residents he sychotropic medication orders. Measures/ Systemic Change: The Administrator, Medical Direct end review with the Pharm	d reconciled ffected by d psychotro this allege have open-e tor and the hacy Const	the drug the allege opic drugs d deficient ended or pr e DON wi altant thos
	irregularities to the at facility's medical direct and these reports mu (i) Irregularities inclu	de, but are not limited to, any iteria set forth in paragraph		ti T a C	sidents who receive psychotropic at prn orders have a stop date and he Medical Director will educ ddressing recommendations onsultant and discuss the regula ided prn orders for psychotropic r	l are recond ate all phy by the tion prohib	viled. ysicians o Pharmacis piting open

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		ND HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTR G	1	FORM APPROVE <u>MB NO, 0938-039</u> 3) DATE SURVEY COMPLETED
		475033	B. WING			C 06/09/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREATAD	DDRESS, CITY, STATE, ZIP CODE	
CRESCEN	IT MANOR CARE CTRS				CENT BLVD GTON, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	during this review muse separate, written repo- attending physician a director and director of minimum, the resident and the irregularity the (iii) The attending phy- resident's medical reo- irregularity has been action has been taken be no change in the m physician should door the resident's medical §483.45(c)(5) The face maintain policies and drug regimen review to limited to, time frames the process and steps when he or she identifier requires urgent action This REQUIREMENT by: Based on interview a	noted by the pharmacist ist be documented on a port that is sent to the and the facility's medical of nursing and lists, at a at's name, the relevant drug, e pharmacist identified. ysician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in I record. cility must develop and procedures for the monthly that include, but are not is the pharmacist must take if ies an irregularity that in to protect the resident. is not met as evidenced and record review, it was	F 7	56 50% Mont order The I Gired The I medi chart repor The or his Infec Worl ensu	onitor: On 7/30/2021, The DON/des of residents on psychotropic drugs thly basis to ensure there are no ope	and on a n-ended prn to the Medical Meeting. ly pharmacy ent's medication be immediately ledical Director ector of Nursing, Services, Social Manager to
	determined that the fat the physician acted u	acility failed to ensure that pon a pharmacy medication I or 20 residents (Resident				
	regimen review was of on 3/29/21 with the for "Currently has an acti [as needed] without s note that CMS [Center Medicaid] guidelines of	do not allow maintaining r PRN psychotropic's on				

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#### PRINTED: 08/03/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING С 11 475033 B. WI NG 06/09/2021 NAME OF PROVIDER OR SUPPLIER STREAT ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD CRESCENT MANOR CARE CTRS BENNINGTON, VT 05201 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE З TAG TAG DEFICIENCY) F 756 Continued From page 27 ł F 756 consider discontinue Hydroxyzine prn and change to standing dose of 50 mg [milligrams] gd [every day], if appropriate." The physician failed to follow up on the above recommendation. Review of the policy and procedure, titled, "Medication Monitoring Medication Regimen 1 Review and Reporting", dated 09.08 Section 8.1. ł under "PROCEDURES" #6 reads, "Resident-specific MRR [Medication Regimen Review) recommendations and findings are documented and acted upon by the nursing care center and/or physician." Interview on 6/8/21 at approximately 2 PM, with the Unit Manager, revealed that she/he had a call out to the doctor regarding the pharmacists recommendation that the physician had not responded to. The Unit Manger confirmed that - 3 Resident #27 does use this PRN medication daily. Residents affected by this alleged deficient practice: F 758 F 758 Free from Unnec Psychotropic Meds/PRN Use Resident #27 was not affected by this deficient practice. CFR(s): 483.45(c)(3)(e)(1)-(5) SS=D The MD immediately reviewed and reconciled the drug søgimen. §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that <sup>2</sup>Residents that could be affected by the alleged affects brain activities associated with mental deficient practice: processes and behavior. These drugs include, All residents who receive as needed psychotropic drugs but are not limited to, drugs in the following have the potential to be affected by this alleged deficient categories: practice. (i) Anti-psychotic; 1) (ii) Anti-depressant; 3 Measures/ Systemic Change: (iii) Anti-anxiety; and Cn 7/8/2021, The Pharmacist educated the medical (iv) Hypnotic director, nurse practitioner, DON and the Nurse Educator on the ordering of prn psychotropic Based on a comprehensive assessment of a niedications. resident, the facility must ensure that---

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CENTERS STATEMENT C AND PLAN OF NAME OF PF CRESCEN (X4) ID PREFIX	S FOR MEDICARE & M PF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER T MANOR CARE CTRS SUMMARY STA (EACH DEFICIENCY	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	A. BUILDING B. WING 31 34 B UD PREFIX	TREFT ADDRESS, CITY, STATE, ZIP CODE 12 C LESCENT BLVD 3EN MINGTON, VT 05201 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	JLD BE COMPLETION
TAG	Continued From page §483.45(e)(1) Resider psychotropic drugs ar unless the medication specific condition as of in the clinical record; §483.45(e)(2) Resider drugs receive gradual behavioral intervention contraindicated, in an drugs; §483.45(e)(3) Resider psychotropic drugs pu- unless that medication diagnosed specific con- in the clinical record; a §483.45(e)(4) PRN or are limited to 14 days. §483.45(e)(5), if the a prescribing practitione appropriate for the PR beyond 14 days, he or rationale in the resider indicate the duration f §483.45(e)(5) PRN or drugs are limited to 14 renewed unless the at prescribing practitione the appropriateness o This REQUIREMENT by:	hts who have not used e not given these drugs is necessary to treat a liagnosed and documented hts who use psychotropic dose reductions, and hs, unless clinically effort to discontinue these hts do not receive rsuant to a PRN order is necessary to treat a hdition that is documented and ders for psychotropic drugs Except as provided in ttending physician or r believes that it is N order to be extended is he should document their ht's medical record and for the PRN order. ders for anti-psychotic days and cannot be tending physician or r evaluates the resident for	<ul> <li>psychotrop there must</li> <li>The medic</li> <li>The Nurse revised po medication</li> <li>4.Monitor for four we appropriat randomly</li> <li>The DON</li> <li>The Medic committee</li> <li>The Medic committee</li> <li>The QAPI designee, I Prevention Coordinato and sustain</li> </ul>	The DON/ designee will audit 10 reveals to ensure prin psychotropic dru te stop date. Audits will continue on the reafter. Will present the results of the audit in cal. Director will present the audit re- e at least monthly. I committee consists of The Medical Executive Director, Director of Nur- nist Environmental Services, Social or and Dietary Manager to ensure co	he policy on ordering of rmation clearly states is after the order. ith all attendings. ucate all nurses on the of psychotropic esident records weekly ig orders have an a monthly basis then to the Medical Director. sults to the QAPI Director or his sing, Infection Worker, MDS
	determined that the fa (as needed) orders for limited to 14 days for 2	cility failed to ensure PRN psychotropic drugs were resident in a sample size ent #27). Findings include:			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	,			SURVEY LETED
		475033	B. WING				09/2021
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F 758	Continued From pag	e 29	F 7	58	TAG F 758 POC Accepted 8/17/21 by P.Cota	on	
	revealed several Pha Reviews (MRR) with recommendation: "C for Hydroxyzine pro- Please note that CM Medicaid] guidelines open ended orders f medication profiles. consider discontinue to standing dose of £ day], if appropriate." recommendations wa not been acknowledg as of this survey date PRN medication is d Interview on 6/8/21 at the Unit Manager, with has been a long star resident does use th stated that she/he hap physician regarding to receive clarificatio and perhaps making There is no evidence Gradual Dose Reduce attempted for this rea- this facility on 10/26/ Interview on 6/8/21 at	Currently has an active order without a specified stop date. S [Centers for Medicare and do not allow maintaining or PRN psychotropic's on Please evaluate and Hydroxyzine prn and change 50 mg [milligrams] qd [every The last MRR with these as made on 3/29/21 and has ged by the ordering physician e. The original order for this ated 5/31/2019. At approximately 2 PM with the confirmed that this order nding PRN order and that the is PRN every day. She/he as a call out to the ordering this medication and is hoping n specific to its long term use it a scheduled medication. a in the medical record that a ction (GDR) has been sident since her admission to 18. At approximately 2:30 PM with		and a set of the set of	9 9		
	the DON (Director of standing use of this evidence of a GDR r also unable to find su	Nursing) regarding the long PRN medication and no evealed that the DON was upporting evidence of a GDR ontinued PRN order for this					
IRM CMS-256	7(02-99) Previous Versions Ob	solete Event (D:KN5N11	1	Facility 12		tinuation sheel	Page 30 of
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		475033	B. WNG		C 06/09/2021
NAME OF PI	ROVIDER OR SUPPLIER			IRE TADDRESS, CITY, STATE, ZIP CODE	0010072021
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			B	ENMINGTON, VT-05201	1.27 M
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 761 SS=E	Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of §483.45(h)(1) In accor Federal laws, the faci biologicals in locked of temperature controls, personnel to have accor §483.45(h)(2) The face locked, permanently a storage of controlled the Comprehensive D Control Act of 1976 and abuse, except when t package drug distribut quantity stored is min	<ul> <li>(1)(2)</li> <li>of Drugs and Biologicals</li> <li>a used in the facility must be</li> <li>a with currently accepted</li> <li>s, and include the</li> <li>y and cautionary</li> <li>expiration date when</li> <li>f Drugs and Biologicals</li> <li>ordance with State and</li> <li>lity must store all drugs and</li> <li>compartments under proper</li> <li>and permit only authorized</li> </ul>	F 761	<ul> <li>Residents affected by this alleged of No residents were affected by the plactice.</li> <li>The following was immediately correct of the following was immediately correct of the one of the o</li></ul>	is alleged deficient ected: of Nurses/ designee nza vaccine from the age room. signee discarded the rom the North Unit signee discarded the and reordered from signee discarded the ftgels. rking the North Hall ed cart when noted o be affected by this be affected by this
	by: Per direct observatio facility failed to ensur- stored and labeled pro- use when expired. Fir 1. On 06/7/21 at 4:01	PM during observation of		when not actively monitored labeling all dru (including vials) Checking all dru	ing but not limited og medication carts v in use and being gs when opened gs in refrigerator, and medication
	open, unlabeled, mult Vaccine was in the me	cation storage room, an i dose vial of Influenza edication refrigerator. The is present at the time of the			xpiration dates and

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CENTER STATEMENT		ND HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A- BUILDING		PRINTED: 08/03/202 FORM APPROVE( OMB NO: 0938-039 (X3) DATE SURVEY COMPLETED
		475033	B. WING		C 06//09/2021
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
CRESCEN	NT MANOR CARE CTRS			312 ्रस्टेडेटेंडिंग BLVD BENNINGTON, VT 05201	
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F 761	vials should be tabled opened and discarde S/he confirmed that to tabled with the date in During an interview w Staff Development Ni approximately 4:15 P dose vials should be opened and discarde 2. During the North U observation on 6/7/20 to store medications w behind the nurse's sta confirmed that the ca that s/he did "not usu when unattended. On 6/7/2021 at 4:30 If the North Unit medica opened multi dose via diagnosis of tubercula date that it was open- confirmed that the via opened. During obser medication carts, the eye drops that were r were opened, and an softgels. At the time of Nurse confirmed that tabled when opened expired. S/he also co and expired medication use. Per interview with the 06/09/21 08:26 AM the	hat s/he believed multi dose d with the date they were d after 28 days of opening. he Influenza vaccine was not t was opened. with the Infection Control/ urse on 6/7/2021 at M s/he confirmed that multi tabled at the time they are d after 28 days. Init medication storage 021 at 4:23 PM the cart used was observed unlocked ation. The Charge Nurse rt was unlocked and stated ally" keep the cart unlocked PM, during observation of ation storage room, an al of Tubersol (used to aid in osis) was not tabled with the ed. The Charge Nurse I had not been dated when rvation of the North Unit re was an opened bottle of not tabled with a date they expired bottle of Fish Oil of observation, the Charge the eye drops were not and the Fish Oil was nfirmed that the unlabeled ons should be removed from	F 761	<ul> <li>All nurses on the revised polic</li> <li>Monitor: On 7/13/2021, The Nur designee will conduct weekly med of mediation refrigerators and med carts) to ensure there are no expire medications are dated/labeled and ocked. After 4 weeks monthly aud conths and then randomly.</li> <li>Noncompliance will be corrected</li> <li>The Nurse supervisor/designee will CON.</li> <li>The DON will report findings to the dast monthly.</li> <li>The QAPI committee consists of The his designee, Executive Director infection Preventionist, Environme Vorker, MDS Coordinator and Dise hsure compliance is achieved and Fesponsible Person: DON Completion Date: 7/31/21</li> </ul>	ies (above). rse Supervisor/ ication storage audits I storage areas (med d meds, opened medication carts are lits will be done for 3 immediately. I report findings to the ne QAPI committee at The Medical Director r, Director of Nursing, ental Services, Social etary Manager to sustained.
ORM CMS-256	57(02-99) Previous Versions Obs	olete Event ID:KN5	N11 Fa	cility f0: 475033 If cor	otinuation sheet Page 32 of

CENTER		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		l coi	FORM OMB NC	): 08/03/202 / APPROVE ) <u>. 0938-039</u> SURVEY
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		475033	B. WING		l06/	09/2021
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(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	designated staff resp expired meds are ren use. In the past the U responsible to do so a	onsible to ensure that noved and discarded from	F 761		TAG F 761 POC Accepted on 8/17/21 by P.Cota	
	on the North side/hall unlocked medication the nurses station. S the nurses station an nurses station while t unlocked. The nurse medication cart was i adjacent to the nurse observation. The unlu- not within her/his visu minutes - from the tim nurse returned to the	PM while doing observations I (Dementia Unit), an cart was discovered, behind everal residents walked past d 2 LNA's entered the he medication cart was responsible for this n the dining room, which is s station at the time of this ocked medication cart was ial sight for at least 8 he it was discovered until the medication cart. At 3:28 as assigned to that cart,			Residents affected by this alleged deficient ractice: o residents were affected by the alleged de ractice. n 6/7/2021 the unlabeled liquid substance alk-in refrigerator was immediately discar n 6/7/2021 The thawing meats were imme moved from the top shelf and placed on th the first the tom the top shelf and placed on th the first the tom the top shelf and placed on th the first the tom the top shelf and placed on the the first the tom the top shelf and placed to the the first the tom the top shelf and placed to the the first the tom the the the the the the top shelf the tom the top shelf and the top shelf the tom the top shelf and the top shelf and the top shelf the tom top shelf the	ficient e in the ded. ediately e low tables,
	responsible for the ur stated she/he usually cart before leaving th an infrequent occurre Food Procurement,St CFR(s): 483.60(i)(1)(2	ore/Prepare/Serve-Sanitary 2)	F 812	0 F Q Q A tl Č	nmediately discarded. n 6/7/2021 the 5 cabbages, which may have butting, were immediately discarded along w our. n 6/8/2021 the 2 operating fans were turn of removed until they could be properly ar oroughly cleaned or replaced. n 6/7/2021 the microwave oven in the sou	vith the ned off nd nth
	state or local authoriti	re food from sources ed satisfactory by federal,		re C te t Q	tchen unit was immediately discarded and placed. n 6/9/7 the refrigerator on the north unit imporarily put out of service until proper mperature could be achieved. n 6/9/21 a new refrigerator was installed placing the defective refrigerator	

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES 1 FORM APPROVED 12 **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 475033 B. WING 06/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD CRESCENT MANOR CARE CTRS BENRINGTON, VT 05201 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 2.Potential for those residents to be affected: F 812 Continued From page 33 F 812 All residents who eat facility prepared food have the from local producers, subject to applicable State potential to be affected. and local laws or regulations. (ii) This provision does not prohibit or prevent 3.Measures/Systemic Change: facilities from using produce grown in facility $O_a 6/14/2021$ the Education Nurse or designee gardens, subject to compliance with applicable educate the Dietary Manager and dietary staff safe growing and food-handling practices. regarding: (iii) This provision does not preclude residents The proper storage of produce, placement of ٠ from consuming foods not procured by the facility. 14 food storage in refrigeration. Proper refrigerator temperature, proper . §483.60(i)(2) - Store, prepare, distribute and freezer temperatures, logging and reporting serve food in accordance with professional temperatures out of range. standards for food service safety. Assessment of fresh produce, rotation of fruits • This REQUIREMENT is not met as evidenced vegetables and foods. by: • Proper storage of meats: frozen, thawing and Based on observation, staff interview and record storin g cooked meats. review, the facility failed to store, prepare, i • Labeling of foods in the refrigerator / freezer. distribute and serve food in accordance with 1 professional standards for food service safety. Proper cleaning of microwave ovens. . Findings include: Proper storage of scoops/utensils used in dry • storage bulk products are properly stored. 1. During the initial kitchen tour on 06/07/21 at 3. Monitor: 11:14 AM, the following observations were made The Dietary Manager or designee will conduct 1 in the walk-in refrigerator: audits of all fresh produce to ensure freshness and safe use. 諉 a. There is a 2 quart metal container containing The Dietary Manager or designee will conduct an unknown liquid substance. The container is audits to observe placement of foods in uncovered and unlabeled. refrigerator to ensure meats are not thawing or 1 b. There is thawing raw and cooked meats on the leaking below onto other foods. top shelf of a wire rack. There are uncovered 11 . The Dietary Manager or designee will conduct 1 tomatoes and bagged vegetables on the bottom audits of all unsealed food items to ensure proper shelf of the wire rack directly underneath the labeling. Any items that have been opened and are thawing meats. not labeled will immediately be discarded. c. There are 5 cabbages on the bottom shelf of a 1 The Dietary Manager or designee will conduct . wire rack that appear to be rotting. They are soft 1 audits of all microwaved to ensure cleanliness. to touch and have extensive brown/black areas The Dietary Manager or designee will conduct . on the surface. audits of all fans in the kitchen area to ensure i. cleanliness. 2. In the dry storage room there is a 1 cup scoop left inside the bulk flour bin, instead of being

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A, BUILDING		(X3) DATE SURVEY COMPLETED C
		475033	B. WING	<u> </u>	06/09/2021
	Rovider or supplier		312	REST ADDRESS, CITY, STATE, ZIP CODE CIESCENT BLVD RENTON, VT 05201	8 a
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION}	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC
F 812 F 880 SS=K	stored outside of the contaminating the flo 3. There are 2 operat room. The fans are b and are soiled with d 4. In the South Unit H oven used daily is so foodstuffs. There is v The Maintenance Dir not aware of the over it should be replaced 5. Per observation or the North Unit read 6 is confirmed by the U AM The Food Service this observation at 11 tested with a facility i was at 46.4 degrees Infection Prevention a CFR(s): 483.80(a)(1) §483.80 Infection Con The facility must esta infection prevention a designed to provide a comfortable environm development and trar diseases and infection program. The facility must esta	flour bin, potentially ur. ing fans in the dishwasher lowing over clean dishware ust. kitchenette, a microwave iled inside with spilled isible flaking paint and rust. ector stated that he/she was n's condition and stated that immediately. n 6/8/21 - A refrigerator on 0 degrees Fahrenheit. This init Charge Nurse at 11:19 e Director also confirmed 1:23 AM, and a pudding instant read thermometer Fahrenheit. & Control (2)(4)(e)(f) ntrol blish and maintain an and control program a safe, sanitary and hent and to help prevent the ismission of communicable ins. prevention and control blish an infection prevention (IPCP) that must include, at	F 812	The Dietary Manager audits of the nursi temperature logs to ensu- maintained.	ed weekly for 4 week en randomly thereafte esent the results of th t least monthly. of The Medical Director Director, Director of cionist, Environmenta Coordinator and Dietar ance is achieved an nager

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			PRINTED: 08/03/2021 FORM APPROVED
<u>CENTER</u>	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		475033	B. WING		C
NAME OF P	ROVIDER OR SUPPLIER	410000	1	STRE #T ADDRESS, CITY, STATE, ZIP CODE	06/09/2021
				12 CRESCENT BLVD	
CRESCER	IT MANOR CARE CTRS		E	BENMINGTON, 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 I CROSS-REFERENCED TO THE APPROPRI	COMPLETION
F 880	§483.80(a)(1) A systere porting, investigatinand communicable distaff, volunteers, visit providing services unarrangement based us conducted according accepted national stars §483.80(a)(2) Writter procedures for the probut are not limited to: (i) A system of survei possible communicable disease reported; (ii) When and to whore communicable disease reported; (iii) Standard and transit to be followed to previous for the previous in the facility (ii) When and how is consident; including but (A) The type and durate depending upon the ininvolved, and (B) A requirement that least restrictive possible communicable disease or infected secondact with residents contact will transmit the (vi) The hand hygiene by staff involved in directions and the stars of the top of the provide the top of the previous provides and the p	em for preventing, identifying, ag, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following ndards; a standards, policies, and ogram, which must include, llance designed to identify ble diseases or can spread to other ; n possible incidents of se or infections should be asmission-based precautions rent spread of infections; lation should be used for a t not limited to: ation of the isolation, nfectious agent or organism t the isolation should be the ble for the resident under the s under which the facility ees with a communicable cin lesions from direct s or their food, if direct he disease; and procedures to be followed rect resident contact. m for recording incidents	F 880	<ul> <li>deficient practice:</li> <li>N&gt; residents were affected by this a plactice.</li> <li>All glucometers were immediately on manufacturer's guidelines.</li> <li>Ecoployees not wearing masks correction mediately directed to place their position.</li> <li>2. Residents at risk for this alleged d <ul> <li>All residents who require mglucose levels or testing have be affected by this alleged of the staffected by this alleged deficient practice.</li> </ul> </li> <li>All residents within 6 feet proximitely wearing masks properly have the affected by this alleged deficient practice.</li> <li>All residents within 6 feet proximitely be affected by this alleged deficient practice.</li> <li>All residents within 6 feet proximitely be affected by the Nurse Consultant of the staffected by the Nurse Consultant of the staff and residents.</li> <li>Policy/procedures for the masks were reviewed wite education/demonstration staff and residents.</li> </ul>	lleged deficient deaned per ectly were masks in proper eficient practice: nonitoring of blood ve the potential to deficient practice. cy of employees not ne potential to be notice. aroot cause analysis ctice. Based on that the put in place. ated all staff on the of masks during ment, covering both otecting vulnerable amilies. erly demonstrating k. ing peers of correct lpful' tips to protect proper use of face th all staff during
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	MEDICAID SERVICES	(X2) MULTIPLE	PRINTED: 08/03/ FORM APPRC OMB NO. 0938-( LE CONSTRUCTION (X3) DATE SURVEY
DRRECTION	IDENTIFICATION NUMBER:	A BUILDING _	COMPLETED
	475033	B. WING	
IDER OR SUPPLIER		s	STRE TADDRESS, CITY, STATE, ZIP CODE
MANOR CARE CTRS		1	312 CRESCENT BLVD BENNINGTON, VT 05201
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
lentified under the fa orrective actions tak 483.80(e) Linens. ersonnel must hand ansport linens so as fection. 483.80(f) Annual rev he facility will condu CP and update thei his REQUIREMENT y: Based on observation eview of facility polic nsure infection contr ut to maintain reside otential infections. T eopardy severity lev Per observation on uring a medication a urse checked the blo for to giving insulin ucometer, which is un dutilizes a sample ood glucose level. S edication cart, remo ucometer and place awer of the cart witt fter a few more med her residents, the n ame, potentially cont neck the blood gluco ithout cleaning the g ocedure, and once a	acility's IPCP and the en by the facility. le, store, process, and to prevent the spread of iew. ct an annual review of its r program, as necessary. is not met as evidenced ns, staff interviews and ies, the facility failed to ol measures were carried nt safety from the spread of his is cited at the Immediate el. Findings include: 06/09/21 at 11:00 AM, dministration pass, a staff bod glucose of a resident using a device called a used for multiple residents of resident blood to obtain a b/he returned to the wed the test strip from the d the device in the top hout cleaning the device. ications were delivered to urse proceeded to use the aminated glucometer to se level of another resident, lucomter prior to or after the again placed the potentially	F 880	<ul> <li>All licensed nursing staff were educated on the necessity of cleaning glucometer after each resident and the risk of improper cleansing poses to residents.</li> <li>Every nurse required to demonstrate proper cleaning technique of glucometers.</li> <li>Review revised Glucometer cleaning powith special emphasis on frequency cleaning with all licensed nurses.</li> <li>The Nurse Educator will provide compete evaluations on glucometer cleaning for evicensed staff person.</li> <li>4Monitor:</li> <li>Gn 6/14/2021, The DON/designee will conduct d rounds throughout the building to ensure that all employ a'e wearing face masks correctly.</li> <li>Any inconsistencies will be immediately corrected.</li> <li>He Nurse Educator 'designee will conduct rand blood glucose meter cleaning audits on every shift ensure the practice meet the professional standards audits will continue on a weekly basis until 10 compliance is observed and then monthly x 30 days beficiencies will be corrected immediately with furthe ducation and progressive discipline as required. The DON will present the results of the audits to the CAPI committee at least monthly. The QAPI committee on sists of The Medical Director or his designee, Executive Director, Director of Nursing, Infection Preventionist, Environmental Services, Social Worker, MDS Coordinator and Dietary Manager to ensure compliance is achieved and sustained.</li> </ul>
	COR MEDICARE & DEFICIENCIES     DEFICIENCIES     DEFICIENCIES     DEFICIENCIES     DEFICIENCIES     DEFICIENCIES     SUMMARYST     (EACH DEFICIENCI     REGULATORY OR I      ontinued From page     lentified under the fa     orrective actions tak     483.80(e) Linens.     ersonnel must hand     ansport linens so as     fection.     483.80(f) Annual rev     he facility will condu     PCP and update thei     his REQUIREMENT     /:     Based on observation     eview of facility polic     nsure infection contr     ut to maintain reside     othertial infections. T     eopardy severity leve     Per observation on     uring a medication a     urse checked the blo     for to giving insulin     ucometer, which is u     nd utilizes a sample     ood glucose level. S     edication cart, remo     ucometer and place     awer of the cart witt     fer a few more med     her residents, the m     me, potentially cont     me, potentially cont     for the cart witt     fer a few more med     her residents, the m     me, potentially cont     function cant     fer a few more med     her residents, the m     me, potentially cont     for the cart witt     fer a few more med     her residents, the m     me, potentially cont     for the cart witt     fer a few more med     her residents, the m     m     me, potentially cont     for the cart witt	DRRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         475033         //DER OR SUPPLIER         MANOR CARE CTRS         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY Full, REGULATORY OR LSC IDENTIFYING INFORMATION)         ontinued From page 36         lentified under the facility's IPCP and the prrective actions taken by the facility.         483.80(e) Linens.         ersonnel must handle, store, process, and ansport linens so as to prevent the spread of fection.         483.80(f) Annual review.         he facility will conduct an annual review of its PCP and update their program, as necessary.         his REQUIREMENT is not met as evidenced	EOR MEDICARE & MEDICAID SERVICES         DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         DENTIFICATION NUMBER:       A BUILDING         A BUILDING       475033         MANOR CARE CTRS       ID         SUMMARYSTATEMENTOF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         PREFIX TAG       ID         ontinued From page 36       F 88/ lentified under the facility's IPCP and the orrective actions taken by the facility.       F 88/ 483.80(e) Linens.         ersonnel must handle, store, process, and ansport linens so as to prevent the spread of faction.       F 88/ 483.80(f) Annual review.         he facility will conduct an annual review of its C/P and update their program, as necessary. his REQUIREMENT is not met as evidenced // fased on observations, staff interviews and wiew of facility policies, the facility failed to nsure infection control measures were carried at to maintain resident safety from the spread of obtential infections. This is cited at the Immediate sopardy severity level. Findings include:         Per observation on 06/09/21 at 11:00 AM, uring a medication administration pass, a staff irse checked the blood glucose of a resident for to giving insulin using a device called a ucometer, which is used for multiple residents and utilizes a sample of resident blood to obtain a ood glucose level. S/he returned to the edication cart, removed the test strip from the ucometer and placed the device in the top awer of the cart without cleaning the device. fer a few more medications were delivered to her residents, the nurse proceeded to use the mme, potentially contaminated

Event ID:KN5N11

Facility 10: 475033

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		ID HUMAN SERVICES		2	FORM APPROVED
		MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	MSTRUCTION	(X3) DATE SURVEY COMPLETED
		475033	B. WING		C 06/09/2021
NAME OF PF	ROVIDER OR SUPPLIER		STRI	TADDRESS, CITY, STATE, ZIP CODE	
CRESCEN	T MANOR CARE CTRS			RESCENT BLVD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 880	shared device for all n strip is what comes in blood and not the device device does not need use. S/he stated that Cavi-wipes prior to ear were found at the nur medication cart. A review of the facility Rehabilitation Policy a Glucose Monitoring b specifies if meter is di cloth to remove debris to monitoring by resid able to perform self-g glucometers and not the assistance. The resid medication pass requi have their own glucor Review of the ASSUF Monitoring System me manual indicates on p should be cleaned an each patient. On page Healthcare, Bleach G Hospital Cleaner Disin Bleach, CaviWipes 1 Germicidal Disposable listed. The Center for Diseas the following: Blood glucose meters blood glucose levels. -Whenever possible, I	d that the glucometer is a residents and that the test contact with the resident's rice itself, therefore the to be disinfected after each the device is cleaned with ach shift. These Cavi-wipes ses' station and not at the policy: Crescent Manor and Procedure Blood y Resident (06/25/2018) rty, use a moist dampened s. This policy also pertains ents who are cognitively lucose testing with their own o those who require ents observed during the ired assistance and did not meters. E PRISM blood Glucose anufacturer instruction/user bage 38 that the meter d disinfected after use on a 39 it states to use Clorox ermicidal Wipes, Dispatch, offectant, Towels with and PDI Super Sani-Cloth e Wipes with contact times are devices that measure blood glucose meters an individual person and		TAG F 880 POC Accepted o 8/17/21 by P.Cota	DN

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

				11		FORM APPRO	
		MEDICAID SERVICES	1			OMB NO. 0938-0	1381
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	F	STRUCTION	(X3) DATE SURVEY COMPLETED	
		475033	B. WING			C 06/09/2021	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STRI-	TADDRESS, CITY, STATE, ZIP CODE	1 00.00.1011	
CRESCEN	NT MANOR CARE CTRS		0		RESCENT BLVD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	iD PREFIX TAG	1.4	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		TION
F 880	Continued From page	28					
F 000		500	F 88	0			
	not be shared.		1	.1			
	-	ers must be shared, the					
		aned and disinfected after					
		acturer's instructions, to					
		blood and infectious agents.	1				
		bes not specify how the	1	а 			
	1	aned and disinfected, then it					
	should not be shared			1			
		njectionsafety/blood-glucose		1			
	-monitoring.html			E.			
	Der interview en 06/0	0/24 at 1:20 DM the muree					
		9/21 at 1:30 PM the nurse		1			
		eventionist confirmed facility	1				
	-	meter. S/he also indicated	1	Ť			
		are that the meters needed		1			
	to be cleaned betwee	•		분			
		neter manual instructions		1			
	_	e, s/he acknowledged that	1	18			
	this is a breach of the	infection control process.					
(	2 On 6/7/21 at annro	ximately 3:20 PM while		P			
	doing observations or		1	10			
		ff nurse was observed		1.1			
	l` '	ses station wearing her			i t		
	surgical mask under l	5		1			
	On 6/8/21 at approxin	nately 1:45 PM a staff nurse		1 1			
		nurses station on the South		1			
		his surgical mask under	1	1			
	-	me nurse was observed at		1			
		t 2:24 PM on the South		1			
		his surgical mask under		- 60			
		in, this staff nurse was		4			
		ng her/his surgical mask					
	under her/his nose at	-		1			
				10			
	On 6/8/21 at 2 PM 2 s	staff (unknown disciplines)					
		ring their surgical masks		11			
		other staff (unknown					
	and the second s	and the second s	L		1777.0.1		_
JKM CMS-256	7(02-99) Previous Versions Obs	olete Event ID:KN5N11	I F	acılıty 🐑	: 475033 If contin	uation sheet Page 39	of A

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If continuation sheet Page 39 of 41

PRINTED: 08/03/2021

FORM APPROVED

CENTER STATEMENT C		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		OMSTRU	CTION	FORI OMB N( (X3) DATE COM	D: 08/03/202 M APPROVE D. 0938-039 E SURVEY PLETED	
		475033	B. WING _					C 06/09/2021	
NAME OF P	ROVIDER OR SUPPLIER		1	STR	E T ADD	RESS, CITY, STATE, ZIP CODE			
CRESCEN			312 GRESCENT 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(X5) COMPLETION DATE	
F 880	disciplines) were obs masks under their no On 6/8/21 at approxir with the staff nurse of had been observed a mask under her/his n names of the 4 staff r their masks either un- chin, as well as her/h confirmed that the 4 of LNA's (Licensed Nurse explained that she/he keeping the mask up sliding down. It was top of the mask had r her/his nose. The sta appropriate use of the over the nose and the On 6/8/21 at approxir conversation with the specific to the South nurses station, it was wearing her/his mask throughout the conve On 6/9/21 at 9:15 AM outside of room 24, a from the linen cart an her/his mask under her Interview on 6/9/21 at	erved to be wearing their ses. mately 2:05 PM an interview in the South side/hall, who t 1:45 PM wearing her/his ose was asked for the full members observed wearing der their nose or under their is full name. The staff nurse other staff members were ses Aides). The staff nurse was having a hard time on her/his nose as it kept noted the metal bar at the noted the metal bar at the noted the metal bar at the noted the metal bar at the e masks was to wear them e mouth. mately 2:40 PM a P DON (Director of Nursing) hali/Unit, while sitting at the noted that the DON was under her/his nose rsation.	F8	80					
		nately 1:30 PM, a staff o wearing her/his mask			j: y.jp: 475			et Page 40 of 4	

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DEPARTN	MENT OF HEALTH A	ND HUMAN SERVICES		¥		d: 08/03/20 Mapprove	
CENTERS FOR MEDICARE & MEDICAID SERVICES			ĩ		DWB NO	<u>), 0938-03</u>	
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	- 105 E	COM	(X3) DATE SURVEY COMPLETED	
		475033	B, WING			C	
	OVIDER OR SUPPLIER	410000		RIU: TADDRESS, CITY, STATE, ZIP (		/09/2021	
	T MANOR CARE CTRS		312	CRESCENT BLVD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
	on the South side/ha Interview on 6/9/21 a a staff nurse on the S that the person at the person and she/he s mask over her/his no On 6/9/21 at 1:30 PM Educator/Infection P wearing of mask, she are to be worn to cov	while working at the linen cart Il outside of room 26. It approximately 1:32 PM with South side/hall, confirmed e linen cart was a laundry hould be wearing her/his use and mouth. If an interview with the Nurse reventionist regarding the e/he confirmed that masks /er the nose and mouth and forn throughout the facility	F 880				
				the state of the s	Ŕ		
				1			
			11 Facili	(y-1/2) 475033	If continuation shee		

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