VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

May 3, 2023

Ms. Shannon McHale, Administrator
Crescent Manor Care Ctrs
312 Crescent Blvd
Bennington, VT 05201-0170

Dear Ms. McHale:

Enclosed is a copy of your acceptable plans of correction for the investigation survey conducted on **April 18, 2023.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475033	A. BUILDING _____ B. WING _____	C 04/18/2023

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

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F 000	INITIAL COMMENTS An unannounced on-site investigation of an anonymous complaint was conducted 4/17-4/18/23 by the Division of Licensing and Protection. There were regulatory violations identified as a result of this investigation.	F 000		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the resident environment remains as free of accident hazards as is possible, regarding the integrity of Hoyer lift transfer slings. Findings include: On 4/17/23 at approximately 10:30 AM a tour of the facility was conducted with the Director of Nursing (DON) during which the resident rooms, clean linen closets, common areas and laundry area were observed, specifically to visualize the lift slings used by the facility (lift slings are designed to be connected to a mechanical lift allowing a person with impaired mobility to be moved from one place to another while suspended in the sling). During this tour, 28 slings were viewed, including 3 Hoyer lift slings noted to have various sized	F 689	**F-689 – Free of Accidents/Hazards/Supervision/Devices** **I. The following actions were accomplished for the residents identified in the sample:** No residents were identified in the sample. The slings identified as being in disrepair were removed from service. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** All residents had the potential to be impacted by the deficient practice. A full house audit was conducted to inspect all slings and no further slings were identified as being in disrepair. The Mechanical Lift Transfer Policy & Procedure was reviewed and updated. All Nursing, Rehab Laundry and Maintenance staff were re-educated on the revised policy. **III. The following system changes will be implemented to assure continuing compliance with regulations:** Residents will be issued an appropriately sized hoyer sling for use during their stay. The sling will be labeled with the resident's name.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/3/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 slits, tears, and holes along seam lines. Two of these impaired slings were found in the clean linen storage areas, one on the west wing and one on the dementia unit. The DON confirmed that items in the clean linen storage area are considered ready for use. The third impaired sling was in the soiled laundry area, having recently been collected from one of the units. Per the DON, the facility currently has 9 residents who are transferred with the use of the Hoyer lift. Sling #1 (green) was identified by the DON as a bariatric sized Hoyer lift sling noted to have 2 open areas on the corners of the seam between the back support and the seating area. These open areas measured 3cm x 0.5 cm and 3.5cm x 1 cm. Sling #2 (green) also identified as a bariatric sized Hoyer lift sling, had numerous open areas along the same seam line, one is a 6cm slit on the upper right side, 3 smaller slits along the bottom seam area measured 0.5cm, 2cm, 1cm. 3 additional slits on the left side along the seam measured 4.5cm, with 2 other slit areas measuring 1cm each. Sling #3 (blue) identified as an average sized Hoyer lift sling was found in the soiled linen, therefore minimally handled but noted to have 2 tears appearing to be at least 2 cm apiece, along the seam behind the neck support area. At 11:00 am during an interview with a LNA, one of the impaired slings was displayed and the LNA was asked if this appeared ready for use. The LNA considered the impaired areas and stated "I think it's still safe for use" pointing to where she/he believed the integrity of the sling is important for safety. When asked if she/he would use the sling in its current condition the LNA responded "it would probably hold". At 2:00 pm	F 689	All nursing, rehab and laundry staff will be educated on the new policy and procedure for issuance of hoyer slings going forward. The inspection of the slings has been added to the Maintenance checklist for inspection according to manufacturer's recommendations. Competency for use of the hoyer has been scheduled for all current Nursing and Rehab staff and will be required at new hire orientation going forward. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** The hoyer slings will be inspected weekly x 4 weeks and monthly x 3 months to ensure there are no slings that are in use that are in disrepair. New Hire education files for Nursing and Rehab staff will be audited weekly x 4 weeks and monthly x 3 months to ensure staff are proving competency in use of the hoyer lift at hire. Results of the audits will be reviewed in the QAPI committee meeting x 4 months for further resolution if needed. **Completion Date: ____05/26/2023_____** **Responsibility: ____Director of Nursing_____** **Tag F 689 POC accepted on 5/3/23 by H. Fox/P. Cota**	

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F 689	Continued From page 2 two other LNA's were interviewed regarding their knowledge of Hoyer sling use, when asked how to choose which size to use on individual residents LNA #1 stated she/he would "use the green ones for bigger people and blue for smaller", LNA #2 stated "no one ever said how to differentiate". Reviewed Crescent Manor Mechanical Lift Transfer Policy and Procedure. It does not address how to choose sling size, does not address assessing equipment or sling for signs of wear or damage, nor is there a date of review of this policy and procedure. Invacare Owner's Operator and Maintenance Manual-Patient Slings, provided by the facility, was reviewed and the following passage was noted on page 2: Bleached, cut, torn, frayed or broken slings are unsafe and could result in injury. Discard immediately. This information was conveyed to the DON and the facility administrator at approximately 4:00 PM.	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761	**F-761– Label/Store Drugs and Biologicals** **I. The following actions were accomplished for the residents identified in the sample:** No residents were identified in the sample. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** All residents had the potential to be impacted by the deficient practice.	

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F 761	Continued From page 3 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to store all drugs and biologicals in locked compartments under proper temperature control, and permit only authorized personnel to have access to the keys. Findings include: On 4/18/23 at approximately 10:30AM, 2 grocery-sized brown paper bags stapled shut were observed in a public area of the facility, with a white printer-sized paper containing the following message: "Pharmacy (pharmerica) to pick up. Return's from Crescent Manor Bennington, VT". The bags were observed in the vestibule on a bench in the entrance of the facility. This unlocked vestibule is passed through by anyone entering or leaving the facility not using a staff entrance, it is also out of the direct sight line of the front office staff. The DON (Director of Nursing) was asked what the contents were, and he/she advised the surveyor that there were medications being retuned to the pharmacy in the bags and added that they were not narcotics. Upon request, the	F 761	Contents of the stapled shut brown bag identified and labeled as "Pharmacy to pick up. Returns from Crecent Manor, Bennington, VT" were verified. Nothing was missing from the bag. No residents were impacted by this deficient practice. **III. The following system changes will be implemented to assure continuing compliance with regulations:** The Pharmacy Return Policy was reviewed and revised. Pharmacy returns will be locked in the med room, under proper temperature control, until pick up by the pharmacy. The medications will be returned in a secure container. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** Pharmacy returns will be audited weekly x 4 weeks and monthly x 3 months to ensure proper storage until pick up. Results of the audit will be reviewed in the QAPI committee meeting x 4 months for further resolution if needed. **Completion Date: ____05/26/2023_____** **Responsibility: ____Director of Nursing_____** **Tag F 761 POC accepted on 5/3/23 by H. Fox/P. Cota**	

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F 761	Continued From page 4 DON opened the bags revealing 19 bubble packs (cards in which each pill is individually packed into a "bubble" the nurse pops open to dispense the individual pill) containing approximately 532 tablets/capsules and 1 tube of medicated cream. The bags contained a variety of medications including diuretics (to lessen fluid accumulation in the body), anti-coagulants (blood thinner), anticonvulsants, antidepressants, as well as cardiac and respiratory medications. These bubble packs were labeled with individual resident names and also included in each bag was a photo copy of the label from each bubble pack also containing the residents name and the name of the medication.	F 761		
F 940 SS=E	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to develop implement and maintain an effective training program for all new and existing staff regarding use of mechanical lifts and dementia training. Findings include: On 4/17/23 while investigating the use of Hoyer lifts (a mechanical lift to assist with moving	F 940	**F-940 Training Requirements** **I. The following actions were accomplished for the residents identified in the sample**: No residents were identified in the sample. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** All residents had the potential to be impacted by the deficient practice. All residents who require use of the mechanical lift for transfer will be issued a hoyer sling for use during their stay at the facility. An audit was conducted of all employee education files to determine documentation of training regarding the use of mechanical lifts and dementia training.	

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F 940	Continued From page 5 individuals with impaired mobility, the individual is suspended in the air in a sling while being moved) with torn or otherwise impaired lift slings, several Licensed Nursing Assistant (LNA) interviews were conducted. At 11:00 AM one of the impaired slings was displayed and a LNA was asked if this appeared ready for use. The LNA considered the impaired areas and stated "I think it's still safe for use" pointing to where she/he believed the integrity of the sling is important for safety. When asked if she/he would use the sling in its current condition the LNA responded "it would probably hold". At 2:00 PM two other LNA's were interviewed regarding their knowledge of Hoyer sling use, when asked how to choose which size to use on individual residents LNA #1 stated she/he would "use the green ones for bigger people and blue for smaller", LNA #2 stated "no one ever said how to differentiate". At 2:00 PM during an interview with the Director of Nursing (DON) she/he confirmed the facility employs agency staff including LNA's stating "they get the same orientation and training as regular staff". Per review of 11 LNA training records (9 of traveling staff and 2 facility staff) it was noted the records contained various documents without discernable standardization. LNA Orientation/Validation packets were reviewed when present in individual files. Upon further questioning on 4/18/23 at 9:00 AM the DON stated he/she is aware the training and training records are not in order and referred the surveyor to the staff educator who has been in his/her position for 6 weeks. On 4/18/23 the staff educator was interviewed at 9:30 AM, he/she stated that LNA skills competency including the use of a Hoyer lift is	F 940	All current staff, including agency staff, identified as not having proper documentation of the required 8 hours of classroom dementia education will be required to complete the 8 hours of training before being scheduled on North Unit. No residents were impacted by this deficient practice. **III. The following system changes will be implemented to assure continuing compliance with regulations:** All nursing and therapy staff will be re-educated on the use of the mechanical lift with an associated return demonstration competency. All newly hired direct care staff, including agency staff, will receive the 8 hours of required dementia training in the classroom prior to being scheduled on North Unit. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** New Hire education files, including new agency staff, will be audited weekly x 4 weeks and monthly x 3 months to ensure proper documentation of education regarding the use of mechanical lifts and dementia training. Results of the audit will be reviewed in the QAPI committee meeting x 4 months for further resolution if needed. **Completion Date: ___05/26/2023_____** **Responsibility: ____Director of Nursing_____**	

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F 940	Continued From page 6 evaluated and documented through use of the LNA Orientation/Validation Packet. A review of the packet reveals it is 10 pages containing over 70 areas for evaluation including use of the Hoyer lift. Of the 11 training records reviewed, 7 do not contain this packet or any documentation confirming competence, of those that are complete, it is noted another LNA was the evaluator, the area in which a nurse is to sign confirming competence is blank or signed by another LNA with one exception where a nurse signed. The staff educator confirmed that the training records and competency evaluations are incomplete. During this conversation the staff educator was asked about the provision of the mandatory 8 hours of dementia training for agency staff as there is scant documentation to validate this and this facility has a designated dementia unit. Per the staff educator the staffing agency is provided with videos and a training document for staff that are to be sent to this facility with an expectation that the agency ensures the staff are provided with the training. The agency staff are also given a post-test to validate competence in dementia care that they are to complete and bring with them on their first day in this facility the test is then given to the medical records person who scores it. The staff educator admitted this does not seem to meet the requirement for 8 hours of training nor does it ensure competence.	F 940	**Tag F 940 POC accepted on 5/3/23 by H. Fox/P. Cota**	