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

November 13, 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 complaint investigation conducted on **October 23, 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

Enclosure

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475033	A. BUILDING _____ B. WING _____	C 10/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced investigation of a facility reported incident (ACTS #22326) on 10/23/2023 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by another resident for one applicable resident (Resident #1). Findings include: Record review reveals that Resident #1 has a diagnosis of dementia with psychosis and was assessed on 8/22/23 to have a BIMS of 4 (brief interview for mental status; a cognitive	F 600	**F-600- Free from Abuse and Neglect** **I. The following actions were accomplished for the residents identified in the sample:** The care plan for Resident #1 was reviewed and revised. The care plan for Resident #2 was reviewed and revised. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** All residents on North unit had the potential to be impacted by the deficient practice. Upon review, there were zero additional residents impacted by the deficient practice. Nursing Staff assigned to North Unit were educated on the revised Care Plan for Resident #1. Nursing Staff assigned to North Unit were educated on the revised Care Plan for Resident #2. The facility's Resident Abuse policy was reviewed without revision.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE LNHA | (X6) DATE 10/30/23

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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

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F 600	Continued From page 1 assessment score indicating severe cognitive impairment). Resident #1's care plan states that s/he "wanders throughout hall/facility/into others room R/T [related to] dementia and independent mobility," revised on 9/5/23, and has interventions that include, "Distract [Resident #1] from wandering by offering pleasant diversions, structured activities, food, conversation, television, book," revised on 2/15/23, and "Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate," created on 12/16/21. Resident #2 has a diagnosis of vascular dementia and was assessed on 9/19/23 to have a BIMS of 9 (indicating moderately impaired cognition). Resident #2's care plan states that s/he "has potential to be physically aggressive r/t Dementia," revised on 7/7/23, and "[Resident #2] wanders throughout hall R/T dementia, confusion," revised on 7/7/23, and has interventions that include "Anticipate [Resident #2's] needs: food, thirst. toileting needs, comfort level, body positioning, pain etc.," revised on 11/3/22, and "Distract [Resident #2] from wandering by offering pleasant diversions, structured activities, food, conversation, television, book," revised on 11/3/22. Review of a facility incident report dated 10/2/23 at 9:30 PM for Resident #1 reveals that Resident #1 was found in another resident's room with bruising on his/her face, blood on his/her clothing, and blood on the floor of the room. Review of a facility resident to resident altercation investigation summary dated 10/9/23 reveals that Resident #1 was wandering the hallway around	F 600	**III. The following system changes will be implemented to assure continuing compliance with regulations:** RN Supervisors and LPN charge nurses who work on North Unit were educated to assign a staff member on the evening and night shifts to monitor the hallway to identify and redirect wandering residents appropriately on North Unit. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** An audit will be conducted weekly x 4 weeks and monthly x 3 months to ensure a staff member is assigned to monitor the hallway on all evening and night shifts on North Unit. Results of the audits will be reviewed in the QAPI committee meeting x 4 months for further resolution if needed. **Completion Date:** **11/02/2023** **Responsibility: Director of Nursing** **Tag F 600 POC accepted on 11/13/23 by S. Stem/P. Cota**	

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F 600	Continued From page 2 10:00 PM when Resident #2 joined Resident #1 in wandering the halls. While walking past Resident #2's room, Resident #1 tried to move a locked wheelchair in the hall. Resident #2 took the wheelchair and hit Resident #1 in the legs with it. Resident #2 then took his/her closed fist and struck Resident #1 in the nose, which then began to bleed. The summary states that this altercation was not witnessed by staff. A nursing note dated 10/5/23 reveals that discoloration continued to be present to Resident #1's nose and bilaterally around the eyes. A social service note dated 10/5/23 reveals that while Resident #1 could not recall how s/he got the bruise on his/her nose, s/he did report that it was sore. Per interview on 10/23/23 at approximately 1:30 PM, the Director of Nursing stated that the altercation between Resident #1 and #2 reported in the investigation summary was confirmed by watching video footage of the event while investigating the cause of Resident #1's bloody nose. S/He stated that the video revealed that when Resident #2 punched Resident #1 in the face, Resident #1 fell to the floor. S/He stated that the investigation determined that the root cause of the altercation was due to the wheelchair being left in the hall and a lack of supervision of residents. See F689 for more information.	F 600		
F 689 SS=G	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	F 689	**F-689 – Free of Accidents Hazards/Supervision/Devices** **I. The following actions were accomplished for the residents identified in the sample**: The care plan for Resident #1 was reviewed and revised. The care plan for Resident #2 was reviewed and revised.	

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F 689	Continued From page 3 §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 interview and record review, the facility failed to ensure that all known and foreseeable hazards in the resident's environment were eliminated and failed to provide sufficient supervision to each resident for 2 applicable residents (Resident #1 and #2) resulting in Resident #1 being physically abused. Findings include: Record review reveals that Resident #1 has a diagnosis of dementia with psychosis and was assessed on 8/22/23 to have a BIMS of 4 (brief interview for mental status; a cognitive assessment score indicating severe cognitive impairment). Resident #1's care plan states that s/he "wanders throughout hall/facility/into others room R/T [related to] dementia and independent mobility," revised on 9/5/23, and has interventions that include, "Distract [Resident #1] from wandering by offering pleasant diversions, structured activities, food, conversation, television, book," revised on 2/15/23, and "Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate," created on 12/16/21. Resident #2 has a diagnosis of vascular dementia and was assessed on 9/19/23 to have a BIMS of 9 (indicating moderately impaired cognition). Resident #2's care plan states that s/he "has potential to be physically aggressive r/t	F 689	**II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** All residents on North Unit had the potential to be impacted by the deficient practice. Upon review, there were zero additional residents impacted by the deficient practice. Nursing Staff assigned to North Unit were educated on the revised Care Plan for Resident #1. Nursing Staff assigned to North Unit were educated on the revised Care Plan for Resident #2. The facility's Fall & Injury Prevention Protocol Policy was reviewed and revised. All Nursing Staff were re-educated on the revised Fall & Injury Prevention Protocol Policy. **III. The following system changes will be implemented to assure continuing compliance with regulations:** All Nursing Staff were re-educated to ensure that hallways remain clear of all equipment not in use. All Nursing Staff were re-educated to ensure that residents are adequately supervised on all shifts.	

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F 689	Continued From page 4 Dementia," revised on 7/7/23, and "[Resident #2] wanders throughout hall R/T dementia, confusion," revised on 7/7/23, and has interventions that include "Anticipate [Resident #2's] needs: food, thirst. toileting needs, comfort level, body positioning, pain etc.," revised on 11/3/22, and "Distract [Resident #2] from wandering by offering pleasant diversions, structured activities, food, conversation, television, book," revised on 11/3/22. Review of a facility resident to resident altercation investigation summary dated 10/9/23 reveals that Resident #1 was wandering the hallway around 10:00 PM when Resident #2 joined Resident #1 in wandering the halls. While walking past Resident #2's room, Resident #1 tried to move a locked wheelchair in the hall. Resident #2 took the wheelchair and hit Resident #1 in the legs with it. Resident #2 then took his/her closed fist and struck Resident #1 in the nose, which then began to bleed. The summary states that this altercation was not witnessed by staff. A nursing note dated 10/5/23 reveals that discoloration continued to be present to Resident #1's nose and bilaterally around the eyes. A social service note dated 10/5/23 reveals that while Resident #1 could not recall how s/he got the bruise on his/her nose, s/he did report that it was sore. Per interview on 10/23/23 at approximately 1:30 PM, the Director of Nursing (DON) stated that the altercation between Resident #1 and #2 as described in the 10/9/23 investigation summary was confirmed by watching video footage of the event. The DON explained that the video footage revealed that Residents #1 and #2 were	F 689	**IV. The facility's compliance will be monitored utilizing the following quality assurance system:** An audit will be conducted weekly x 4 weeks and monthly x 3 months to ensure hallways are free from equipment not in use. Results of the audits will be reviewed in the QAPI committee meeting x 4 months for further resolution if needed. **Completion Date: 11/02/2023** **Responsibility: Director of Nursing** **Tag F 689 POC accepted on 11/13/23 by S. Stem/P. Cota**	

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F 689	Continued From page 5 wandering for approximately 10 minutes without supervision. S/He stated that a staff member should be monitoring the hallway at all times during the off shifts (indicating that this took place during an off shift) and that if the residents were supervised, this incident would not have occurred because staff would have been able to intervene. S/He stated that resident equipment, such as wheelchairs, should not be left in the hallway when not in use. S/He confirmed the root cause of the altercation was due to the wheelchair being left in the hall and a lack of supervision of residents.	F 689		