

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

March 6, 2014

Mr. Dovid Glenn, Administrator
Crescent Manor Care Ctrs
312 Crescent Blvd
Bennington, VT 05201-0170

Dear Mr. Glenn:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 5, 2014**. Please post this document in a prominent place in your facility.

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

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl

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

PRINTED: 02/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/05/2014
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NAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS	STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD BENNINGTON, VT 05201
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(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
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F 000 INITIAL COMMENTS

An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection from 2/3/14 to 2/5/14. There were regulatory deficiencies identified. The findings include:

F 226 483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview the facility failed to implement written policies and procedures that prohibit abuse for 1 staff member accused of abuse. The findings include:

1. Per review of the facility internal investigation on 2/3/14. Resident #1 alleged on 7/29/13, a facility staff member had "molested" him/her. Per review of the facility investigation, the staff member was instructed by the facility Administrator not to be alone with Resident #1 until after the facility investigation was completed.

Per interview with the facility Activity Director (AD) on 2/4/14, the AD confirmed in interview that he/she had been accused by Resident #1 of "molesting" him/her and that the facility Administrator met with the AD on 7/30/13 and indicated that he/she could not have any contact with Resident #1. The AD confirmed that he/she

F 000

F 226

F226

Resident #1 was unaffected

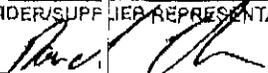
All residents are at risk

All department heads will be educated on abuse allegations policy.

Administrator and DNS will oversee all investigations.

Compliance date 3/5/14

F226 POC accepted 3/6/14 pmetaran

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 3/3/14
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any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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.

PMK

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F 226 Continued From page 1
continued to work on 7/30/13 with other residents in the facility. The AD confirmed that he/she was told by the facility Administrator that he/she should be suspended without pay pending the outcome of the facility investigation but since the Administrator knew the staff member didn't abuse Resident #1, he/she could work during the facility's investigation of the alleged incident. The staff member confirmed in interview on 2/4/14, he/she worked with other residents in the facility except for Resident #1 during the investigation on 7/30/13.

F 226

Per review of the facilities policy and procedure titled "Resident Abuse", the policy indicates that "if a staff member is the alleged perpetrator, the staff member will be suspended without pay during the investigation of the incident."

F 282 SS=D 483.20(k)(5)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

F 282

F282
Care plans for resident #3 & #4 were reviewed

All residents can be affected

Activity staff will be given copy of care plan summary, including behaviors and in-serviced on resident behaviors.

Unit manager will observe activity / dining room to insure behaviors are dealt with properly.

Compliance date 3/5/14

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview the facility failed to provide or arrange services by qualified persons in accordance with each resident's written plan of care for two residents identified (Resident #3, #4). The findings include:

1. Per review of the facility internal investigation dated 12/3/13 and medical record, Resident #3 was in a common area with other residents on

F282 POC accepted 3/6/14 P.M. Octavio

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F 282

Continued From page 2

12/2/13. Resident #3 was repetitively repeating out loud "I get my ginger ale at 2, 4 and 6." The internal investigation indicated in the staff statements that Resident #3 was repeating the same phrase over and over and "everyone was getting agitated". Another employee statement and nurses notes indicated that Resident #4 was yelling at Resident #3 to shut up and that Resident #4 was yelling that he/she was going to hit Resident #3. The investigation indicates that Resident #3 walked across the room, and he/she was hit by Resident #4 as Resident #3 walked by.

Per review of the medical record of Resident #3, he/she was admitted to the facility on 8/24/13 with diagnoses that include Schizophrenia and dementia. Per review of the medical record, Resident #3 has a history of making repetitive statements. Per review of the comprehensive care plan titled "Resident at risk for abuse by other residents and/or staff related to agitated behaviors", dated and initiated on 7/5/14 indicates that staff is to "Attempt to reduce environmental stimuli as able", and "Attempt to remove to quiet area if resident becomes agitated or aggressive" and "attempt non-pharmacological interventions for behaviors/agitation I.E.; reorientation, redirection, activities, offer food/drink, monitor for pain, 1:1 etc."

Per review of the internal investigation and the medical record there is no evidence that the staff initiated any of the interventions on the care plan to prevent the resident to resident altercation on 12/2/13.

Per interview with the Unit Manager on 2/5/14, he/she reviewed the internal investigation, the

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F 282 Continued From page 3

medical record and the care plan for Resident #3 and confirmed that Resident #3 had behaviors that included the repetitive verbalization of certain phrases. The UM also confirmed that there was no evidence that the facility staff implemented the care plan for Resident #3 to diffuse and prevent any altercation between Resident #3 and Resident #4 on 12/2/13. The UM indicated that the interventions on the care plan if they had been implemented it may have prevented the altercation where Resident #3 was hit by Resident #4.

Per review of the medical record of Resident #4, he/she was admitted to the facility on 10/26/09 with diagnoses that include Alzheimer's with delusions, dementia with behavioral disorder and intermittent agitation. Per review of the medical record, Resident #4 has a history of aggressive behaviors towards others. Per review of the comprehensive care plan titled "Resident at risk for abuse by other residents and/or staff related to history of verbally assaulting or slapping other residents/staff", dated 07/31/13, it indicates that staff is to "Attempt to reduce environmental stimuli as able", and "Attempt to remove to quiet area if resident becomes agitated or aggressive", "increase surveillance when agitated and safety needs increase," and "attempt non-pharmacological interventions for behaviors/agitation I.E.; reorientation, redirection, activities, offer food/drink, monitor for pain, 1:1 etc."

Per review of the internal investigation and the medical record there is no evidence that the staff initiated any of the interventions on the care plan to prevent the resident to resident altercation on 12/2/13.

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F 282

Continued From page 4

F 282

Per interview with the Unit Manager on 2/5/14, he/she reviewed the internal investigation, the medical record and the care plan for Resident #4 and confirmed that Resident #4 had behaviors that included verbal and physical aggression towards others. The UM also confirmed that there was no evidence that the facility staff implemented the care plan for Resident #4 to diffuse and prevent any altercation between Resident #3 and Resident #4 on 12/2/13. The UM indicated that the interventions on the care plan if they had been implemented may have prevented the altercation where Resident #3 was hit by Resident #4.

F 323
SS-D

483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

F 323

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review and staff interview the facility failed to ensure that 3 residents identified (Resident #5, #3 & #4) receive adequate supervision and assistance devices to prevent accidents and altercations. The findings include;

1. Per review of the facility internal investigation

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F 323	<p>Continued From page 5</p> <p>and the medical record, on 10/1/13 Resident #2 slapped Resident #5 on the left upper arm when Resident #5 attempted to remove Resident #2's wheelchair from his room. Per review of the medical record for Resident #5, he was admitted on 10/26/12, with diagnosis of senile dementia with delusional features, persistent mental disorder and anxiety.</p> <p>Per review of the medical record, Resident #5 has a long history of wandering on the unit in and out of rooms and being involved in resident to resident, physical altercations and falls. The medical record indicates that on 3/1/13 Resident #5 was slapped in face by another resident, 4/3/13 and 6/24/13 Resident #5 slapped on back by another resident, on 8/29/13 Resident #5 pushed by another resident after entering residents room.</p> <p>Per direct observation on 2/3/14 at 1:00 PM, Resident #5 was observed wandering the hallway. Resident #5 entered room 21. The female resident that was in the room in bed at the time started screaming and yelling for Resident #5 to leave. The female resident yelled loudly for approximately 5 minutes for Resident #5 to leave. During this time unit staff were seen in hallway. Resident #5 did not leave room 21. Housekeeping was observed entering the unit and heard the yelling, the housekeeper went into the room and redirected Resident #5 into the hallway, the housekeeper then was observed leaving the unit again. Resident #5 re-entered room 21 where the female resident yelled for several minutes. No unit staff was observed responding to the yelling. Resident #5 after appropriately 6 minutes left room on his/her own and wandered down the hallway. During the time of this observation there were several rooms</p>	F 323	<p>F323 (1)</p> <p>Resident # 5 enjoys walking the hall. Larger <u>black</u> cloth will be replacing stop signs, as a deterrent from entering other residents' rooms.</p> <p>All residents are at risk</p> <p>Supervision of hallway increased, by having available staff, remain in the hallway.</p> <p>Unit manager will report to DNS on effectiveness of plan.</p> <p>Completion date 3/7/14</p> <p><i>F323 POC accepted 3/6/14 Pmatarn (also see next entry)</i></p>	
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F 323

Continued From page 6

observed to have stop signs in front of them unsecured and not blocking the doorways to any rooms, just hanging on the door frame.

Per review of the 15 minute check sheet at 1 PM, the 15 minute check sheet indicated resident was in the hallway. Per review of the comprehensive care plan, and medical record with the UM, he/she confirmed that no other interventions but 15 minute checks were utilized after the altercations.

Per interview with the Unit Manager (UM) he/she reviewed the medical record and the comprehensive care plan he/she confirmed that Resident #5 has a long history of wandering in and out of others rooms and this behavior places Resident #5 at a high risk for resident to resident verbal and physical altercations. The UM confirmed that the "stop signs" were to be placed over doors as a deterrent to residents wandering into others rooms. The UM indicated that Resident #5 just climbs under them when they are across the doorways or takes them down. The UM stated that "they do 15 minute checks to make sure that [Resident #5] stays safe" but that the unit just doesn't have enough staff to place him on a 1:1 with staff. The UM indicated in interview that the 15 minute checks indicate where the resident is at the time of the check but does not account for the resident's whereabouts the other 14 minutes. The UM stated that "they are doing all they can."

Per review of the medical record, Resident #5 has had falls on 12/24/13 found sitting on floor, on 1/2/14 fell backwards while ambulating in the hallway, and on 1/23/14 fell onto his rear end at 2:00 PM and then again at 3:00 PM. Per review of

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F 323

Continued From page 7
the comprehensive care plan dated 10/22/13, there was no evidence that the care plan was revised to reflect the resident's need to wander on the unit or his/hers behavior of wandering in and out of rooms.

Per interview with the UM, he/she reviewed the medical record and the comprehensive care plan and confirmed that resident has noted history of falls, many occurring in residents rooms. The UM indicated that Resident #5 is on 15 minute checks to prevent falls.

2. Per review of the facility internal investigation dated 12/3/13 and medical record, Resident #3 was in a common area with other residents on 12/2/13. Resident #3 was repeatedly repeating out loud "I get my ginger ale at 2, 4 and 6." The internal investigation indicated in the staff statements that Resident #3 was repeating the same phrase over and over and "everyone was getting agitated". Another employee statement and nurses notes indicated that Resident #4 was yelling at Resident #3 to shut up and that Resident #4 was yelling that he/she was going to hit Resident #3. The investigation indicates that Resident #3 walked across the room, and he/she was hit by Resident #4 as Resident #3 walked by.

Per review of the medical record of Resident #3, he/she was admitted to the facility on 6/24/13 with diagnoses that include Schizophrenia and dementia. Per review of the medical record, Resident #3 has a history of making repetitive statements. Per review of the comprehensive care plan titled "Resident at risk for abuse by other residents and/or staff related to agitated behaviors", dated and initiated on 7/5/14 indicates that staff is to "Attempt to reduce

F 323

F323 (2)

Care plans for resident #3 & #4 were reviewed

All residents can be affected

Activity staff will be given copy of care plan summary, including behaviors and in-serviced on resident behaviors.

Unit manager will observe activity / dining room to insure behaviors are dealt with properly.

Compliance date 3/5/14

F323 POC accepted 3/6/14 pmcoran

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F 323	<p>Continued From page 8</p> <p>environmental stimuli as able", and "Attempt to remove to quiet area if resident becomes agitated or aggressive" and "attempt non-pharmacological interventions for behaviors/agitation I.E.; reorientation, redirection, activities, offer food/drink, monitor for pain, 1:1 etc."</p> <p>Per review of the internal investigation and the medical record there is no evidence that the staff initiated any of the interventions on the care plan to prevent the resident to resident altercation on 12/2/13.</p> <p>Per interview with the Unit Manager on 2/5/14, he/she reviewed the internal investigation, the medical record and the care plan for Resident #3 and confirmed that Resident #3 had behaviors that included the repetitive verbalization of certain phrases. The UM also confirmed that there was no evidence that the facility staff implemented the care plan for Resident #3 to diffuse and prevent any altercation between Resident #3 and Resident #4 on 12/2/13. The UM indicated that the interventions on the care plan if they had been implemented it may have prevented the altercation where Resident #3 was hit by Resident #4.</p> <p>Per review of the medical record of Resident #4, he/she was admitted to the facility on 10/26/09 with diagnoses that include Alzheimer's with delusions, dementia with behavioral disorder and intermittent agitation. Per review of the medical record, Resident #4 has a history of aggressive behaviors towards others. Per review of the comprehensive care plan titled "Resident at risk for abuse by other residents and/or staff related to history of verbally assaulting or slapping other</p>	F 323		

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F 323

Continued From page 9 residents/staff", dated 07/30/13, it indicates that staff is to "Attempt to reduce environmental stimuli as able", and "Attempt to remove to quiet area if resident becomes agitated or aggressive", "increase surveillance when agitated and safety needs increase," and "attempt non-pharmacological interventions for behaviors/agitation I.E.; reorientation, redirection, activities, offer food/drink, monitor for pain, 1:1 etc."

Per review of the internal investigation and the medical record there is no evidence that the staff initiated any of the interventions on the care plan to prevent the resident to re-incident altercation on 12/2/13.

Per interview with the Unit Manager on 2/5/14, he/she reviewed the internal investigation, the medical record and the care plan for Resident #4 and confirmed that Resident #4 had behaviors that included verbal and physical aggression towards others. The UM also confirmed that there was no evidence that the facility staff implemented the care plan for Resident #4 to diffuse and prevent any altercation between Resident #3 and Resident #4 on 12/2/13. The UM indicated that the interventions on the care plan if they had been implemented may have prevented the altercation where Resident #3 was hit by Resident #4.

F 323

investigation and the evidence that the staff interventions on the care plan resident altercation on

investigation, the care plan for Resident #4 had behaviors that included verbal and physical aggression towards others. The UM also confirmed that there was no evidence that the facility staff implemented the care plan for Resident #4 to diffuse and prevent any altercation between Resident #3 and Resident #4 on 12/2/13. The UM indicated that the interventions on the care plan if they had been implemented may have prevented the altercation where Resident #3 was hit by Resident #4.