

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

May 8, 2014

Ms. Wendy Beatty, Administrator
Crescent Manor Care Ctrs
312 Crescent Blvd
Bennington, VT 05201-0170

Dear Ms. Beatty:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 21, 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,



Frances L. Keeler, RN, MSN, DBA
Assistant Division Director
State Survey Agency Director

FK:jl

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

RECEIVED
Division of

PRINTED: 04/28/2014
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 _____	MAY - 7 14 Licensing and Protection	(X3) DATE SURVEY COMPLETED C 04/21/2014
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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	F 000		
F 223 SS=D	<p>An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 4/21/14. The following regulatory violations were identified:</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon interview and record review the facility failed to ensure one of 5 residents [Resident #1] of the sample group was not subjected to physical abuse by another resident of the facility. Findings include: Per record review, Resident #1, whose diagnoses include dementia and Alzheimer's disease, has a documented history of wandering in and out of other resident's rooms, and "Inappropriate touching" [e.g. "...touching, kissing, holding hands"] of another resident on the facility's North Wing unit, Resident #2. Per record review of Nursing Notes, on 1/29/14 Resident #2 "grabbed [Resident #1] by [h/her] right arm and pulled [h/her] out of bed onto floor, yanking h/her into hallway". Resident #2 was questioned by staff immediately following the</p>	F 223	<p>F223 Resident #1 & #2 separated</p> <p>Social Services interviewed both residents, no recollection of event by either party</p> <p>Residents who reside in the center have potential to be at risk</p> <p>Education provided to staff regarding abuse and dealing with difficult aggressive/behaviors</p> <p>Staff will redirect residents who wander. Nurse manager will audit compliance weekly X4, monthly X3.</p> <p>Results of these audits will be presented at the monthly QAPI meetings for further discussion and recommendations.</p> <p>Oversight: DNS will monitor for completion</p> <p>Compliance date May 10, 2014</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
WSD

POC accept T. Daugherty / *FKeele*
ADMINISTRATOR
5/8/14
5.5.14

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIDN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2014
NAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS			STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD BENNINGTON, VT 05201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DR LSC IDENTIFYING INFDRMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	Continued From page 1 incident and stated "What would you do if your wife was with him?" referring to Resident #2's roommate. Resident #1 was assessed after the incident, and Nursing Notes record "Abrasion noted left thigh close to hip, red spot upper left arm near axilla [armpit]. Bruise on [h/her] forehead. Small open area above bruise." Per interview with the Unit Manager for Resident #1 & #2 and with the facility's Administrator on 4/21/14, both confirmed Resident #1 had suffered physical abuse by Resident #2 on 1/29/14.	F 223	<i>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Crescent Manor Care Center does not admit that the deficiencies CMS2567 exist, nor does the facility admit to any statement findings, facts, or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</i>		

 5.5.14