



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

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

January 4, 2011

Claudette Werner, Administrator
Crescent Manor Care Ctrs
312 Crescent Blvd
Bennington, VT 05201

Provider ID #:475033

Dear Ms. Werner:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on
December 13, 2010.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota". The signature is written in a cursive style with a large, looped initial "P".

Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure



STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475033	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 12/13/2010
NAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS	STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD BENNINGTON, VT		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 278	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the assessment for 1 applicable resident in the targeted sample did not reflect the resident's status (Resident #1). Findings include:</p> <p>1. Per record review, Resident #1's MDS (Minimum Data Set) dated 8/5/10 and 5/9/10 failed to identify wandering as a behavior the resident exhibited in the look-back period. Per interview with staff on 12/1/10 and review of the applicable Behavior/Intervention Monthly Flow Records, Resident #1 wandered almost daily, and was coded on the behavior record as continuously wandering every day from 8/1/10 to 8/5/10 and also from 5/1/10 to 5/9/10. Per interviews on 12/1/10 at 1:10 PM and 1:20 PM, the MDS Coordinator and the staff member that completed the behavior component of the MDS confirmed the MDS's for 5/9/10 and 8/5/10 did not reflect the wandering behavior for Resident #1.</p>		
F 514	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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F 514	<p>Continued From Page 1 the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to maintain complete and accurately documented clinical records for 1 applicable resident in the sample. (Resident #2) Findings include:</p> <p>1. Per record review on 12/01/10, Resident #2's medical chart had a United Counseling Service (UCS) Individual Plan Goal sheet dated 06/30/09 and an addendum to Individual Plan of Care face sheet dated 07/07/09. Per interview on 12/01/10 at 3:00 PM the Administrator confirmed "that is old information...that shouldn't be in there". In addition, on 12/01/10 at 11:00 AM, the Admission Coordinator was observed inserting UCS support slip visit summaries [dated 11/19/10, 11/24/10 and 11/27/10] into Resident #2's chart stating "We didn't think we needed these". S/he confirmed that this information should be part of the record.</p>		

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

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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 12/13/2010
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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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<p>F 000</p> <p>F 279 SS=D</p>	<p>INITIAL COMMENTS</p> <p>An unannounced onsite complaint investigation was initiated on 12/1/10 by the Division of Licensing and Protection, and completed on 12/13/10.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a comprehensive care plan that included measurable objectives for 1 applicable resident. (Resident #2) Findings include:</p> <p>1. Per record review on 12/01/10, Resident #2's care plan for a history of sexual, socially</p>	<p>F 000</p> <p>F 279</p>	<p>F279.</p> <p>Crescent Manor self-reported incident on 11/24/10.</p> <p>Resident #2 remains in the facility in stable condition.</p> <p>Care Plan was updated to include parameters and objectives when to initiate contact with United Counseling Service. Protocols for UCS interventions will be completed with UCS Director on January 4, 2011.</p> <p>All residents that are currently followed by psych services will have Care Plans reviewed to update parameters and objectives. (All residents in need of psych services will be addressed upon admission and as needed).</p> <p>Assistant DNS will complete stand-up educational meetings with the staff. Nurse Manager, DNS and Assistant DNS will monitor for compliance of new protocols and report findings to CQI committee.</p> <p><i>F279 POC Accepted 1/4/11 [Signature]</i></p>	<p>1/7/11</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Charlotte Warner</i>	TITLE <i>Adm</i>	(X6) DATE <i>12-31-10</i>
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F 279	Continued From page 1 inappropriate behavior did not have quantifiable objectives listed. The interventions listed such approach as "UCS (United Counseling Services) support as indicated"; however, there were no parameters or measurable objectives as to what those indications are. In addition, there was no care plan as to what UCS's support would include. Per interview on 12/01/10 at 1:00 PM the Unit Manager confirmed the care plan did not have measurable objectives and parameters.	F 279			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide services that meet professional standards regarding failure to perform psychiatric evaluations for 1 applicable resident. (Resident #2) Findings include: 1. Per medical record review and interview, Resident #2, who's diagnoses include a mental illness, was not assessed or evaluated after 2 incidents of threatening/aggressive behaviors. Per Nursing notes dated 09/21/10, "was threatening other female residents, threatened to break windows, yelling, upsetting the unit, unable to re-direct, requested police be called." Per review of physician's progress notes, the resident was seen for a routine visit, 2 months later on 11/01/10. On 11/24/10 Nursing staff heard loud yelling from Resident #2 "get [him/her] out of here." Resident #2 was found on the floor, along with Resident #1, and Resident #1 sustained	F281 F 281	Resident #2 remains in the facility in stable condition. Crescent Manor sent resident to the emergency room for evaluation of his aggression on 9/21/10. The emergency room physician evaluated the resident and determined the resident was not in the need for further evaluation with Psych Services. Evaluation was completed by his attending physician 11/1/10 and 12/1/10 as well as psych evaluation by clinician from UCS on 12/23/10, no further intervention were indicated. The protocol for crisis intervention will be updated to address the special needs of this resident.	1/7/11	
			281 The update Protocol for Crisis Intervention will be applied to all residents as needed.		

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F 281	Continued From page 2 serious injuries, requiring transfer to the hospital. Per interview on 12/01/10 at 1:00 PM nursing staff stated that "something was up...you could hear the change in [Resident #2]'s voice." Per the care plan and confirmed by staff, Resident #2 is identified as having aggressive, threatening and/or abusive behaviors. In addition, the nurse stated s/he was "not sure when s/he last seen by the psychiatrist or had a psych eval." Per the progress notes, a standard psychiatric evaluation was not completed to identify risk factors after the above 2 incidents, nor a complete re-evaluation or assessment for at risk behavior. Refer also to F319. Reference: American Psychiatric Association Practice Guidelines 2nd Edition (April 2004) Treatment of Patients with Schizophrenia - Part 1, Section G, #5 "identifying risk factors and assessment for aggressive behaviors is part of a standard psychiatric evaluation and periodic reevaluation for diagnosis and treatment plan"	F 281	Assistant DNS will complete stand-up educational meetings with the staff. Nurse Manager, DNS and Assistant DNS will monitor for compliance of new protocols and report findings to CQI committee. <i>F281 POC accepted 1/4/11 [Signature]</i>	On-going
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents who display mental or psychosocial adjustment difficulty receive appropriate treatment and services regarding psychiatric evaluations for 1 applicable resident in	F 319		

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F 319	Continued From page 3 the targeted sample (Resident #2). Findings include: 1. Per medical record review and interview, Resident #2, who's diagnoses include a mental illness, was not assessed or evaluated after 2 incidents of threatening/aggressive behaviors. Per Nursing notes dated 09/21/10, "was threatening other female residents, threatened to break windows, yelling, upsetting the unit, unable to re-direct, requested police be called." Per review of physician's progress notes, the resident was seen for a routine visit, 2 months later on 11/01/10. On 11/24/10 Nursing staff heard loud yelling from Resident #2's room "get [him/her] out of here". Resident #2 was found on the floor, along with Resident #1, and Resident #1 sustained serious injuries, requiring transfer to the hospital. Per interview on 12/01/10 at 1:00 PM, nursing staff stated that "something was up...you could hear the change in [Resident #2]'s voice." Per the care plan and confirmed by staff, Resident #2 is identified as having aggressive, threatening and/or abusive behaviors. In addition, the nurse stated s/he was "not sure when s/he last seen by the psychiatrist or had a psych eval." Per the progress notes, a standard psychiatric evaluation was not completed to identify risk factors after the above 2 incidents, nor a complete re-evaluation or assessment for at risk behavior. Refer also to F281.	F 319	F319 Resident #2 remains in the facility in stable condition. Crescent Manor sent resident to the emergency room for evaluation of his aggression on 9/21/10. The emergency room physician evaluated the resident and determined the resident was not in the need for further evaluation with Psych Services. Evaluation was completed by his attending physician 11/1/10 and 12/1/10 as well as psych evaluation by clinician from UCS on 12/23/10, no further intervention were indicated. The protocol for crisis intervention will be updated to address the special needs of this resident.	1/7/11
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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.	F 323	The updated protocol for Crisis Intervention will be applied to all residents as needed. Assistant DNS will complete stand-up educational meetings with the staff. Nurse Manager, DNS and Assistant DNS will monitor for compliance of new protocols and report findings to CQI committee.	

F319 POC Accepted 1/4/11 P. McArthur

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F 323	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 1 applicable resident in the targeted sample received adequate supervision to prevent an accident that resulted in serious injury (Resident #1). Findings include: 1. Per interview and record review, Resident #1, who wandered about the unit on an almost daily basis, did not receive adequate supervision to prevent accidents. Per interviews and review of Nurses' Notes (NN) on 12/1/10, Resident #1 was found on the floor in Resident #2's room, along with Resident #2, on 11/24/10 at 5:45 PM. Per staff interview, Resident #2 was heard yelling "get [him/her] out of here" immediately prior to staff finding the residents on the floor. Resident #1 was transferred to the local hospital for treatment of the sustained injuries. Per NN, Resident #1 exhibited behaviors identified as wandering, aggressive behavior, and threatening other residents within 1 week of admission to the facility in February 2010. These behaviors continued, as evidenced by NN and Behavior/Intervention Monthly Flow Records throughout the resident's admission. Per review of the care plan and staff interviews on 12/1/10, Resident #1 was not on any scheduled/structured monitoring or safety checks to assure adequate monitoring of the resident's whereabouts. Per staff interviews and record review on 12/1/10, Resident #1 had a history of wandering into other Residents' rooms, verbally or physically harassing	F 323	Resident #1 expired. The facility has developed individualized wandering care plans which may include timeframes and parameters when necessary. Aggressive behavior interventions will continue to be individualized with one to one monitoring and/or 15 minute safety checks as needed. The facility updated the documentation form for daily assignments to include visualization of residents especially during meal times and at night. The facility has installed a "new" documentation system (Caretracker) which will enhance the ability of the caretaker to document behaviors. Charge Nurse's will continue to document on the Behavior Monitoring Record and/or nurses notes. Assistant DNS will complete stand-up educational meetings with the staff. Nurse Manager, DNS and Assistant DNS will generate behavior reports to assure compliance. Outcomes will be reported to the CQI committee.	On-going 1/7/11	

F323 POC Accepted 1/4/11 P. Motarn

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F 323	Continued From page 5 other residents when entering their rooms, and had entered Resident #2's room in the recent past. The care plan that addresses Resident #1's risk for falls and injury related to poor safety awareness states to "Monitor OOB [out of bed] activity" and "Be aware of Resident's whereabouts." The care plan that addresses increased behaviors related to altered thought process states to "increase surveillance during evenings and nights when confusion and safety needs increase." These interventions do not provide staff with any specific timeframes or monitoring parameters. There is no documentation to support daily increased surveillance during evening hours, nor is there any daily documentation regarding the resident's whereabouts or monitoring of OOB activity. During an interview on 12/8/10 at 11:20 AM, the Assistant Director of Nursing confirmed that there is no documentation to support increased surveillance or knowledge of resident whereabouts during evening hours, and that staff were not given specific guidance on how often to check the location of Resident #1 to ensure safety.	F 323			