



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

August 18, 2010

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

Dear Ms. Werner:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on August 2, 2010. 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,

A handwritten signature in cursive script that reads "Pamela M. Cota RN".

Pamela M. Cota, RN  
Licensing Chief



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

PRINTED: 08/06/2010  
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 08/02/2010
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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
F 000	INITIAL COMMENTS	F 000		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to revise the comprehensive care plan to reflect the current status and needs of one resident in the applicable sample (Resident # 1). Findings include:</p> <p>1. Per staff interview and record review on 8/2/10, the current Care Plan (CP) for Resident #1 was</p>	F 280	<p><b>RECEIVED</b> Division of AUG 17 10 Licensing and Protection</p> <p><b>F280</b> <b>Resident #1 remains in the facility in stable condition.</b></p> <p>Care Plan for Resident #1 has been revised to assess for the need for 1:1 intervention during aggressive behaviors. 1:1 interventions will be noted in the nursing notes or behavior monitoring record.</p> <p>An audit tool to monitor aggressive behaviors has been developed to assure compliance of the need for 1:1 for all residents that require this intervention. This will include auditing of the care plan, nursing notes and/or behavior monitoring record for the next 30 days. The audits will be completed by Staff Development and MDS Coordinator; results will be reported to the CQI Committee. Threshold will be 100% if not met the audits will continue.</p> <p><i>F280 POC Accepted 8/16/10 Pincoturn</i></p>	<p>8/16/10</p> <p>9/16/10</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Clare... Poorman* TITLE *ADM* (X6) DATE *8/16/10*

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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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 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 280	Continued From page 1 not revised to address aggressive behavior which occurred in July, 2010. Nurses Notes (NN) for July, 2010 describe behaviors of Resident #1 that include "pushing at" and scratching staff, "flinging things off both med carts," and kicking staff. The NN on 7/13/10 records an incident when Resident #1 punched a staff member "in the back and proceeded to go out to backyard after another resident." The NN for 7/24/10 describe an incident when Resident #1 provokes another resident to the point where that resident threw coffee at Resident #1. Interview on 8/2/10 at 1:35 PM with the Program Coordinator, and at 2:10 PM with the Director of Nursing (DNS) confirms that the NN document multiple episodes of aggression by Resident #1 in July and that the resident's CP for "Potential for Increased Behaviors, High risk for aggression" has not been revised to address aggressive behaviors since 5/13/10.  2. Per staff interview and record review on 8/2/10, the current CP for Resident #1 for "Potential for Increased Behaviors, High Risk for aggression" lists the following approach: "1:1 staffing to monitor interactions while awake." Per observation on 8/2/10 of Resident #1 in the facility, and confirmed in interview with the Program Manager on 8/2/10 at 1:35 PM and the DNS at 2:10 PM, Resident #1 is not currently on 1:1 staffing.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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F 282	Continued From page 2  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide care and services in accordance with one resident's plan of care. (Resident #1) Findings include:  1. Per observation and record review, the facility failed to ensure that Resident #1 was wearing a personal monitoring device used to alert staff when the resident leaves the facility. For Resident #1, the current care plan for the "Potential for increased behaviors related to altered thought process, impulsivity" includes "Wanderguard left wrist." Confirmed with the Program Coordinator on 8/2/10 at 3:02 PM, Resident #1 was not wearing a Wanderguard bracelet device in accordance with the resident's current plan of care.	F 282	<b>F282</b> <b>Resident # 1</b> took off her monitor minutes before the surveyor exited the building. A new monitor was put immediately back on the resident.  Monitors are checked daily by the unit nurses each shift. Night shift is responsible for monitoring the functioning of these devices.  Audits will be completed weekly to assure compliance. Results will be submitted to the CQI Committee. Threshold will be 100% if not met the audits will continue.  SDC and MDS Coordinator will complete the audits. The Director of Nursing will present outcomes at the CQI meeting.  <i>F282 POC Accepted 8/18/10 PmcotARN</i>		8/16/10  9/16/10