

Division of Licensing and Protection  
103 South Main Street  
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 2, 2015

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 **February 11, 2015**. 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

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

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 02/11/2015
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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	The following constitutes the facility's response to the findings of the Department of Licensing and Protection and does not constitute an admission guilt or agreement of the facts alleged or conclusions set for the summary statement of deficiencies.	
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p>F157</p> <ol style="list-style-type: none"> <li>1. Resident # 1 had no negative effects as a result of this alleged deficient practice.</li> <li>2. All residents who have a fall with injury have the potential to be affected by this alleged deficient practice.</li> <li>3. Staff have been re-educated on the policy and procedure of assessing falls with injury.</li> <li>4. Audits are ongoing to to assure compliance. Results will be reported to the QAPI committee by the DNS for 3 months.</li> <li>5. Corrective action completed March 3,2015.</li> </ol>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE Administrator 3.1.15
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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 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.

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

PRINTED: 02/17/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to notify the physician of an accident that involved injury for 1 of 5 residents reviewed, Resident #1. Findings include:</p> <p>Resident #1 sustained a fall on 2/4/15 at 11:50 AM, from a wheelchair, placing the resident in a prone position (face down) on the floor. Resident sustained a head injury as evidenced by a hematoma to the right forehead, 1 centimeter (cm) laceration to upper gumline, small abrasion to the left knee and large abrasion on the right knee. Per review of the medical record there is no evidence that the physician was notified of the fall with injury resulting. A fax prepared, by the Director of Nursing (DON), for the physician, had a hand written date of 2/4/15 and a stamp mark stating faxed with an area to write in when it was faxed, but this was blank. Another fax stamp was on the page with the date 2/6/15 written in. Per interview with the Director of Nursing on 2/11/15 at 1:25 PM, s/he stated that the fax was sent and there is a confirmation log that can be printed from the phone. The Staff Educator was unable to produce the confirmation as of 5:15 PM and stated that s/he could not provide evidence that the fax had been sent. Further confirmation was made that there is no documentation in the medical record or on the incident/accident report to support the physician was notified. On 2/11/15 at 12:03 PM, per interview with the Licensed Practical Nurse (LPN) that attended the resident immediately following the incident, that s/he had returned to the nursing station, notified the contact person and prepared a fax for the</p>	F 157		
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F 157  F 281 SS=D	<p>Continued From page 2</p> <p>physician. Upon review of the record, there is no evidence of a fax that s/he had prepared, only the one written by the DON. This was confirmed by the staff educator at 2:09 PM on 2/11/15.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to meet professional standards of quality for 2 of 5 residents reviewed, Resident #1 and #2. Findings include:</p> <p>1. Resident #1 sustained a fall on 2/4/15 at 11:50 AM, from a wheelchair, placing the resident in a prone position (face down) on the floor. Resident sustained a head injury as evidenced by a hematoma to the right forehead, 1 cm laceration to upper gumline, small abrasion to the left knee and large abrasion on the right knee. Per documentation in the medical record, the Licensed Practical Nurse (LPN), that first attended the resident after the fall, was the nurse that assessed the situation. There is no evidence that a Registered Nurse (RN) was present. Per review of the facility incident report, there is no evidence that an RN oversaw the assessment. Confirmation that there is no evidence to support an RN conducting the initial assessment following the fall was made by the Director of Nursing (DON) at 1:26 PM on 2/11/15. The DON stated that Resident #1 was all ready on his/ her back and not face down when s/he arrived to the scene</p>	F 157  F 281	<p>F281</p> <ol style="list-style-type: none"> <li>Residents #1 and #2 had no negative effects from this alleged deficient practice.</li> <li>Residents who sustain a fall can be affected as a result of this alleged deficient practice.</li> <li>Policy and Procedure has been developed for assessing falls with injury. Staff have been in-serviced</li> <li>Audits are ongoing to to assure compliance. Results will be reported to the QAPI committee by the DNS for 3 months.</li> <li>Corrective action completed March 3, 2015.</li> </ol> <p><i>F281 POC accepted 3/2/15 B. Bortell RN/PMU</i></p>	

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F 281	<p>Continued From page 3</p> <p>of the incident. The DON further stated that prior to the resident being turned over from her face to her back, s/he did not do an assessment. The DON further stated that it is not a rule at the facility or a policy that states and RN needs to be called for a fall. Confirmation was made by Staff Service Educator (SSE) on 2/11/15 at 2:09 PM, that there is no documented evidence to support that an RN did any part of the assessment for Resident #1 following the fall. S/he also confirmed at this time that the facility policy states that a nurse must provide an immediate clinical assessment and that the State of Vermont views that the nurse doing the assessment is considered an RN.</p> <p>2. Resident #2 sustained a fall on 2/3/15 at 8:00 AM, and documentation in the nursing progress notes present that the writer, an LPN, heard the resident calling out for help and upon entering the room the Resident #2 was found lying on left side with pajama bottoms and underwear around his/her knees, wearing only socks. Per documentation the LPN, 'assessed patient for injuries none apparent'. There is no evidence that an RN did an assessment of the resident's condition. Review of the facilities incident/accident report does not have evidence that the resident was assessed by and RN. Confirmation was made by the SSE at 5:05 PM that there is no evidence to support RN assessment.</p> <p>Reference: Per review of the Vermont Board of Nursing Position Statement titled "THE ROLE OF THE LICENSED PRACTICAL NURSE IN PATIENT ASSESSMENT AND TRIAGE", it states "LPNs may not independently assess the health</p>	F 281		

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F 281	Continued From page 4 status of an individual or group and may not independently develop or modify the plan of care. LPNs may contribute to the assessment and nursing care planning processes; however, patient assessment and care plan development or revision remain the responsibility of the RN, APRN, or other authorized health care practitioner."	F 281		