



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

May 18, 2010

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

Provider #: 475033

Dear Ms. Werner:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 5, 2010**. Please post this document in a prominent place in your facility.

We will 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,

Suzanne Leavitt, RN, MS
Licensing Chief

Enclosure

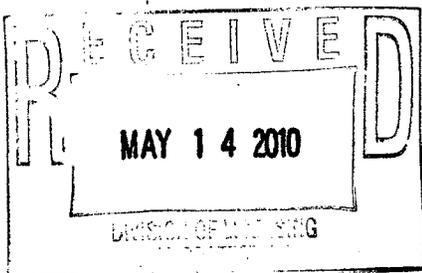


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 05/05/2010
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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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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced onsite complaint investigation was conducted on 5/5/10 by the Division of Licensing and Protection. The following regulatory deficiencies were identified related to the complaint.</p> <p>Based on the information gathered, an Immediate Jeopardy situation was determined to exist based on the facility failure to identify the hazard and risks of the continued use of side rails, the failure to take immediate action after an avoidable accident resulted involving side rails, failure to monitor the effectiveness of implemented interventions to assure the hazard was removed and failure to develop a preventative maintenance plan to assure safe functioning side rails.</p>	F 000		
F 323 SS=K	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the safe working condition of side rails for 5 applicable residents on two units (Residents #1, 2, 3, 4, 5). Findings include:</p> <p>1. Per interview and record review on 5/5/10, the facility failed to implement immediate</p>	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Claudia Wernicke* TITLE: Administrator (X5) DATE: 5/12/10

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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F 323	<p>Continued From page 1</p> <p>interventions to assure all residents's beds with attached half side rails were free from potential hazard after Resident #1 sustained injury from a fall when the side rail on the resident's bed became detached. Per nursing notes, on 4/30/10 at ".... 1535 an LNA heard alarm and resident (#1) calling out, went into room saw resident lying on left side facing his/her bed, rail was on the floor and under her with alarm attached still alarming". Resident #1 required emergency medical intervention and received treatment by a hospital emergency department for a fractured nose and laceration on the forehead above the right eye. Resident #1, who was assessed to be at risk for falls, has right sided mobility deficits, and utilized the half side rails for mobility. Per facility report of incident dated 5/3/10 "Per nursing reports, resident frequently shook the side rails....". Per interview at 2:50 PM with LNA #1, also confirmed "she/he would shake the bar (on the side rail) to get attention". In addition, the LNA stated he/she was not aware of any problems with the side rails, but when Resident #1 was found on the floor the resident stated to LNA #1 "the rail was loose".</p> <p>Per interview on 5/5/10 at 11:50 AM staff from the maintenance department stated he/she had examined the half side rail which had fallen off Resident #1's bed and found there was nothing wrong with the side rail. No further assessment by staff was conducted to verify if other side rails in use were a potential hazard until the maintenance staff person returned to the facility on 5/1/10 to audit all beds with side rails. At that time "...some loosened nuts required tightening".</p> <p>Per observation at 12:03 PM on 5/5/10 the side rail which had fallen off Resident #1's bed was</p>	F 323		
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F 323	<p>Continued From page 2</p> <p>now stored in the facility basement. The half rail measuring approximately 36-40 inches long and 19 inches high (produced by Drive Medical Design & Manufacturer) comes with a "fixed clamp jaw" which is then aligned with the top of a bed frame rail. The clamp is then secured to the bed with a knob which, when turned, secures/tightens the clamp to the bed frame. An additional observation was made of a bed in storage with the same half side rail attached. By shaking and pulling on the side rail, the knob loosened. With repeated shaking of the side rail it was apparent that the side rail could become unattached from the bed frame rail and potentially fall off. This observation was confirmed by the Environmental Director and facility Controller.</p> <p>On 5/1/10 rounds were made from 12:15 PM to 12:50 PM with the Environmental Director, maintenance staff and the facility Controller to assess the status of side rails still in use. During the inspection the "Bed Rail/Bed Bar Audit 5/1/10" developed after Resident #1's accident, was used as a reference to validate what had been previously inspected. Twenty residents were identified from the audit to have half side rails. Prior to the tour, nursing staff had reassessed some residents for the use of the half side rails and chose to remove rails from the beds of some residents. However during the tour, half side rails on the beds of Resident #2 and #3 were found to be loose and when shaken or pulled on, in addition to demonstrating the potential to fall off, also created a space between the mattress and the side rail which was an entrapment hazard with the potential to cause serious injury. Both residents have dementia and are assessed to be at risk for falls. For residents #4 and #5, the half side rails were also noted to be loose and the left</p>	F 323		
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FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 3</p> <p>rail clamp knob on the bed of Resident #5 was partially unscrewed allowing the clamp jaw to be only partially secured to the bed rail frame.</p> <p>Per interview on 5/1/10 the Environmental Director confirmed, although he/she has a monthly preventative maintenance program, there was no preventative maintenance program to ensure side rails were attached and fit properly and were safe for resident use. He/she stated approximately 1 year ago there were issues with loose rails, however maintenance staff had tightened the half side rails, but failed to conduct any routine rechecks or monitoring. The Environmental Director stated he/she was informed by nursing that Resident #1 had "shaken the rail loose". When asked if he/she had manufacturers's instruction on the proper installation of the side rails, the Environmental Director stated he/she did not have any instructions. Previous maintenance staff that had worked at the facility had demonstrated to the Environmental Director how to install the side rails. The Environmental Director confirmed he failed to ensure the implementation of the audit conducted on 5/1/10 was effective and that no further hazards existed for those residents still utilizing half rails. In addition, the Environmental Director later confirmed at 1:50 PM he/she did not initiate training or follow up with the maintenance staff regarding monitoring of side rails after the incident on 4/30/10.</p> <p>Per interview at 1:05 PM, the nurse educator stated inservice to the nursing staff regarding the issues involving the side rails were not initiated until 5/4/10, 4 days after the accident involving Resident #1. Per interview at 1:48 PM, the Director of Nurses (DNS) stated he/she was</p>	F 323		

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F 323	Continued From page 4 unavailable on 4/30/10 but upon return to the facility on 5/3/10 he/she ordered a new bed to replace the previous bed used by Resident #1. The DNS acknowledged awareness of the audit of the side rails conducted by maintenance on 5/1/10, however did not evaluate or assess if existing potential hazards remained with the ongoing use of the same half side rails identified in the accident involving Resident #1 or the potential risk for resident entrapment especially with vulnerable residents with dementia.	F 323	F 323 5/12/10 approved POC J. Mitchell / BS	
F 465 SS=K	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure side rails were safe, properly installed, remained secure and were not a risk for entrapment on two units. Findings include: On 4/30/10 Resident #1 fell out of bed and was found laying on top of a side rail that had fallen off the bed. The resident sustained a broken nose and a head laceration requiring emergency intervention. Per interview on 5/5/10 at 11:50 AM staff from the maintenance department stated he/she had examined the half side rail which had fallen off Resident #1's bed and found there was nothing wrong with the side rail.	F 465		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 465	<p>Continued From page 5</p> <p>Per observation at 12:03 PM on 5/5/10 the side rail which had fallen off Resident #1's bed was now stored in the facility basement. The half rail measuring approximately 36-40 inches long and 19 inches high (produced by Drive Medical Design & Manufacturer) comes with a "fixed clamp jaw" which is then aligned with the top of a bed frame rail. The clamp is then secured to the bed with a knob which, when turned, secures/tightens the clamp to the bed frame. An additional observation was made of a bed in storage with the same half side rail attached. By shaking and pulling on the side rail, the knob loosened. With repeated shaking of the side rail it was apparent that the side rail potentially could become detached from the bed frame rail and fall off. This observation was confirmed by the Environmental Director and facility Controller.</p> <p>On 5/5/10 inspection rounds were made from 12:15 PM to 12:50 PM with the Environmental Director, maintenance staff and the facility Controller to assess the status of side rails still in use. During the inspection the "Bed Rail/Bed Bar Audit 5/1/10" developed after Resident #1's accident, was used as a reference to validate what had been previously inspected. Twenty residents were identified from the audit to have half side rails. Prior to the tour, nursing staff had reassessed some residents for the use of the half side rails and chosen to remove rails from the beds of some residents. However during the tour, half side rails on the beds of Resident #2 and #3 were found to be loose and when shaken or pulled on, in addition to demonstrating the potential to fall off, also created a space between the mattress and the rail which was an entrapment hazard. Both residents have dementia and are assessed to be at risk for falls.</p>	F 465		

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F 465	<p>Continued From page 6</p> <p>For residents #4 and #5, the half side rails were also noted to be loose and the left rail clamp knob on the bed of Resident #5 was partially unscrewed allowing the clamp jaw to be only partially secured to the bed rail frame.</p> <p>Per interview on 5/1/10 the Environmental Director confirmed, although he/she has a monthly preventative maintenance program, there was no preventative maintenance program to assure side rails were attached and fit properly and were safe for resident use. He stated approximately 1 year ago there were issues with loose rails, however maintenance staff had tightened the half side rails, but failed to conduct any routine rechecks or monitoring. The Environmental Director stated he/she was informed by nursing that Resident #1 had "shaken the rail loose". When asked if he/she had manufacturers's instruction on the proper installation of the side rails, the Environmental Director stated he/she did not have any instructions. Previous maintenance staff that had worked at the facility had demonstrated to the Environmental Director how to install the side rails. The Environmental Director confirmed he/she failed to ensure the implementation of the audit conducted on 5/1/10 was effective and that no further hazards existed for those residents still utilizing half rails. In addition, the Environmental Director later confirmed at 1:50 PM he/she did not initiate training or follow up with the maintenance staff regarding monitoring of side rails after the incident on 4/30/10.</p>	F 465	<p>F 465 5/12/10 POC Aunt F. Mitchell</p> 	
F 520 SS=K	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		

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F 520	<p>Continued From page 7</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to incorporate into their quality assessment and assurance activities an effective action plan to address the immediate environmental hazard identified for residents who utilized side rails on two units. Findings include:</p> <p>1. Per record review, on 4/30/10 Resident #1 sustained injury after a side rail had detached from the bed, the resident fell out of the bed and was found laying on top of the side rail. During interviews on 5/5/10 the Director of Nurses and the Environmental Director confirmed they failed</p>	F 520	<p>5-520</p> <p>POC complete</p> <p>F. M. White / 18</p>	
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F 520	Continued From page 8 to analyze the audit information obtained by the maintenance staff on 5/1/10 to ensure there was no further potential hazard related to the use side rails. A plan of correction implemented the 4/30/10 to ensure all residents with side rails remained safe was limited to an audit conducted by one member of the maintenance staff. During an inspection of side rails on 5/5/10 by the surveyor, Environmental Director and facility Controller, it was evident 4 resident beds with half side rails remained a hazard for the residents, including the potential to cause serious harm from entrapment.	F 520		
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PLAN OF CORRECTION

Name of Provider or Supplier: Crescent Manor Care Center (the "Facility")

Street Address: 312 Crescent Blvd., Bennington, VT 05201

Provider/Supplier Identification Number: 470533

Date Survey Completed: 5/5/10

Introduction

By letter dated May 7, 2010 the Division of Licensing and Protection of the Department of Disabilities, Aging and Independent Living of the Agency of Human Services of the State of Vermont issued a notification of immediate jeopardy based the results of a May 5, 2010 complaint investigation conducted by the Division, after the Facility self reported a resident fall. The notification of immediate jeopardy recommends to the Centers for Medicare and Medicaid services that the provider agreement of the Agency be terminated effective November 5, 2010. The complaint investigation found immediate jeopardy under federal regulations as cited on the Survey.

This Plan of Correction, as required under regulation, responds to the survey notice for purposes of demonstrating a credible allegation for the removal of immediate jeopardy. For purposes of preparing this Plan of Correction the Facility has assumed the accuracy of the summary statement of deficiencies. However, the Facility has set forth additional, relevant facts and circumstances at the end of this Plan of Correction and the Facility reserves its right to appeal this survey. In response to the summary statement of deficiencies, the Facility offers the following Plan of Correction.

Plan of Correction continued on next page.

ID Tag	Plan of Correction	Completion Date	Responsible Staff
F323	The Facility has discontinued use of portable side rails and will only use side rails that are sold pre-affixed to beds, and soldered to the bed, see attached specifications for beds	5/6/10 & ongoing	Administrator
	Resident #1 was given a new bed with side rails pre-affixed, old side rails were removed, Resident's plan of care includes assistance, physician advised of status	5/6/10	Director of Nursing
	Resident #2 had side rails removed and was given a new, low to floor bed, physician advised	5/6/10	Director of Nursing
	Resident #3 had side rails removed and was given a new, low to floor bed which was later replaced because the lift would not fit under the bed, Resident now has a safety mat, physician advised	5/6/10	Director of Nursing
	Resident #4 had side rails removed and was given a grab bar, see attached specifications, physician advised	5/6/10	Director of Nursing
	Resident #5 had side rails removed because Resident #5 did not use side rails or need a grab bar, no replacement was done	5/6/10	Director of Nursing
	The remaining 15 residents who had side rails were each evaluated for transfer assistance and fall prevention needs, within Continuing Quality Improvement Program with interventions as set forth on attached, de-identified list and pursuant to attached, de-identified side rail assessment inventory, physicians	5/5/10 MD responses rec'd by 5/10	Director of Nursing

were contacted and advised of changes and plans of care were updated; in sum, 10 residents had side rails removed, 5 residents remained in beds with pre-affixed siderails, see bed specifications

<p>Nursing staff, direct care staff, and maintenance staff will be trained to evaluate bed affixed side rails for security and to observe beds to ensure there is no spacing between side rails or grab bars and mattresses that could present an entrapment hazard to resident(s), grab and/or transfer bars will also be evaluated for safety; staff will report patients shaking rails or bars to nursing staff to initiate re-evaluation of needs, in the event of a loose bar or rail, staff will follow emergency preventative maintenance protocol, see attached presentation outline and policy</p>	<p>5/13/10 & ongoing</p>	<p>Director of Education</p>
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<p>Maintenance staff will maintain manufacturer's literature on purchased equipment</p>	<p>5/5/10 & ongoing</p>	<p>Environmental Director</p>
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<p>Evaluation of side rails, grab rails/transfer bars and their security will be added to weekly maintenance program</p>	<p>5/10/10 & ongoing</p>	<p>Environmental Director</p>
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<p>Discharge protocol will be adjusted to require removal of bars and rails from beds on resident discharge</p>	<p>5/12/10 & ongoing</p>	<p>Admissions/Social Services</p>
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<p>Patients will be evaluated on admission by PT/OT on admission to evaluate need for transfer and/or repositioning assistive devices, those residents who require devices will be added to preventative maintenance survey checklist to ensure ongoing</p>	<p>5/10/10 & ongoing</p>	<p>Director of Nursing Rehab</p>
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evaluation of safety of assistive devices (see attached)

F465 Please see response to F323

F520 All instances of significant equipment failure or dysfunction will be reported to the Administrator, or her designee who will devise appropriate additions to the Continuous Quality Improvement Program ("CQI")

Maintenance staff's weekly bed rail and bar checks will be reported to and reviewed by Department Heads within CQI Program

Performance Improvement indicators adjusted to include checking side rail function (#21) with environmental survey, see attached

Facility's Additional Factual Statement

The injury to Resident #1 occurred at 5:35 pm. On that evening, the Administrator was notified and she directed maintenance conduct a thorough audit and inspection of all side rails and transfer bars in the Facility, the next morning, Saturday, May 1, 2010. Given the extent and duration of the Facility's previous use of side rails without incident, the Administrator did not feel it was warranted to disturb resting residents to conduct the inspection that evening. The Director of Nursing was also made aware of the incident that evening. Also on April 30, 2010, the Director of Education spoke to staff on duty to make them aware of the potential for side rails to come loose, and instructed staff to tighten side rails as needed and to do inspections during routine care. Staff was also educated to use the maintenance log to report equipment malfunctions. Rooms #7 and 19 were checked that evening and room #19's side rails were tightened by nursing staff.

On May 1, 2010, maintenance staff conducted a safety audit of all side rails in use in the Facility and submitted the report to the Controller/Administrator in Training. Rails were found to be in good condition with the exception of one for which the handle was replaced. See attached.

Between May 3, 2010 and May 4, 2010, wing managers worked with the Director of Nursing to continue audits and evaluation of appropriateness of side rails for all residents in the Facility. This resulted in a list of appropriate beds for removal of side rails, addition of transfer bars, low beds and addition of mats being prepared for and submitted to staff at morning meeting on 5/5/10.

On May 3, 2010, a meeting of department heads was held to discuss the recent events, and to develop corrective actions.

The Environmental Director confirmed that the "issues" with loose rails approximately a year ago referred to in the statement of deficiencies consist of one maintenance request for tightening of a rail.

The Facility also notes that the re-evaluation of the use of side rails has been part of its Continuous Quality Improvement plan since November 2009. At that time, the Facility completed a 100% audit of side rails, removed an old style of side rails that had been identified as an entrapment hazard, screened residents' needs and updated care plans and assessments. This program was reviewed in a December 2009 survey which did not result in any deficiency related to the use of side rails.