

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

October 31, 2011

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

Dear Ms. Werner-Poorman:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 27, 2011**. 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

PC:jl



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

OCT 24 2011

PRINTED: 10/06/2011
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 09/27/2011
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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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F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>The Division of Licensing and Protection conducted an unannounced on site complaint investigation on 9/27/11. The following regulatory deficiencies were identified:</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to monitor one resident in accordance with the plan of care during the time period when the resident eloped (exited the facility unattended or supervised by staff). (Resident #1). Finding includes:</p> <p>Per record review and confirmed during an interview with the Administrator (ADM) and Director of Nursing (DNS) on 9/27/11 at 2:00 PM, Resident #1 was found on 9/9/11, at 8:45 PM approximately 2 blocks away from the facility and staff were not aware the resident had eloped. Resident #1 was care planned for "Altered Thought Processes - At Risk for Wandering Towards Exits" and included "15 minute checks for continued exit seeking behaviors ". On 9/9/11, the "15 minute checks" were not documented on the "Crescent Manor Care Centers Safety Checks" as having been done from 7:15 PM to 8:45 PM. The last documented check occurred at 7:00 PM.</p>	F 282	<p>F282 Resident #1 at this time is no longer a resident of the facility.</p> <p>Safety checks are completed on all residents that are care planned for safety checks. The safety sheets are signed by the LNA and initial by the Charge Nurse at the end of the shift to assure compliance. On-going</p> <p>The Staff Development Coordinator reviewed the importance of safety checks with all nursing staff. The new Safety Check sheet was presented to all staff including the need for the Charge Nurses to initial at the end of the shift to assure compliance. 9/28/11</p> <p>An audit will be completed and reported to the CQI committee by the Nurse Managers to assure compliance. The outcome of the audits will be reviewed at the CQI Committee.</p> <p>on-going</p> <p><i>F282 POC accepted J. Cumme 10/24/11</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Charlotte Wynn Brown</i>	TITLE Administrator	(X6) DATE 10-19-11
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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.

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F 323 SS=D	<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 upon interview and record review, the facility failed to ensure that one resident received adequate supervision to prevent an elopement from the facility (exited unattended, or supervised by staff). (Resident #1). Finding includes:</p> <p>Per record review and confirmed during an interview with the Administrator (ADM) and Director of Nursing (DNS) on 9/27/11 at 2:00 PM, Resident #1 was found on 9/9/11 at 8:45 PM approximately 2 blocks away from the facility and staff were not aware the resident had eloped. Resident #1 was care planned for "Altered Thought Processes - At Risk for Wandering Towards Exits" and included "15 minute checks for continued exit seeking behaviors ". On 9/9/11, the "15 minute checks" were not documented on the "Crescent Manor Care Centers Safety Checks" as having been done from 7:15 PM to 8:45 PM. The last documented check occurred at 7:00 PM.</p> <p>Per interview on 9/27/11 at 10:45 AM, the Administrator (ADM) stated that Resident #1 may have memorized the exit code to the South Patio</p>	F 323	<p>F323</p> <p>Resident #1 at this time is no longer a resident of the facility.</p> <p>Safety checks are completed on all residents that are care planned for safety checks. The safety sheets are signed by the LNA and initial by the Charge Nurse at the end of the shift to assure compliance. on-going</p> <p>An audit will be completed and reported to the CQI committee by the Nurse Managers to assure compliance. The outcome of the audits will be reviewed at the CQI Committee.</p> <p>The alarm code was changed. The Staff Development Coordinator in-serviced all Staff on the importance of keeping the Alarm code numbers private to protect The residents safety. This code will be changed as the need arises.</p> <p>Environmental Director will monitor the Alarms by checking all alarms weekly; Outcomes will be submitted to the CQI Committee. on-going</p> <p>The Staff Development Coordinator reviewed the importance of safety checks with all nursing staff. The new Safety Check sheet was presented to all staff including the need for the Charge Nurses to initial at the end of the shift to assure compliance. 9/28/11</p>	

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F 323	Continued From page 2 door. Per interview on 9/27/11 at 2:50 PM, the Director of Nursing (DNS) stated Resident #1's Wander Guard (alarm worn by resident to notify staff of exit seeking behavior) was checked after the elopement and found to be functioning correctly.	F 323	<i>F 323 POC accepted J. Cummins 10/24/11</i>	
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to maintain equipment used to monitor residents with exit seeking behaviors in safe operating condition. The findings include: Per observation during a complaint investigation on 9/26/11 at 1:00 PM a test was conducted of the facilities Wander Guard security system used to monitor residents with exit seeking behaviors. During this test, on the South Unit stair well door, it was observed that when a brand new Wander Guard device was placed at ankle level the alarm on the door was not activated. Per interview on 9/26/11 at 12:10 PM with the Nursing Staff Educator, the Wander Guards are placed either on a resident's wrist or their ankle by nursing. Per interview on 9/26/11, with the Environmental Services Manager (EMS) at 1:00 PM, when the Wander Guard device is within up to a three foot distance of the Wander Guard sensor on a doorway an alarm sounds to alert staff. Testing	F 456	D456 The Wanderguard system and door alarms are checked weekly by the Environmental Director. The door leading to the basement which has an alarm will be reviewed by the Alarm Company as to the sensitivity of the alarm: to assure that the alarm goes off whether the bracelet is on the leg of the resident or arm. The Environmental Director will monitor the alarms by checking all alarms weekly, outcomes will be submitted to the CQI committee.	10/18/11 On-going
			<i>F 456 POC accepted J. Cummins 10/24/11</i>	

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F 456	<p>Continued From page 3</p> <p>was performed three times on this doorway and all three times the door sensor did not activate the alarm. The EMS indicated that when the green and yellow lights on the door sensor are lit this indicates that the door sensor is working appropriately. During the alarm testing the green and yellow lights were observed to be on. The EMS stated that there was no process in place to regularly monitor these Wander Guard systems to ensure that they function properly. Per review of the First Q Wander Alert System policy provided by the facility it indicates that the alarm system is to have regular door testing performed. Review of the manufacturer's recommendations for this alarm system, the manufacturer recommends this system be tested weekly on each shift with all surrounding power devices turned on. Per interview the Administrator at 2:15 PM on 9/26/2011 confirmed that the facility policy indicates that regular door testing is to be completed.</p> <p>Per observation on 9/26/11 at 1:00 PM it was observed that a Mag Lock (Key Pad) Security system was also used on several of the facility doorways leading to the outside of the building and to a stairway. Per interview on 9/26/2011 at 1:00 PM the EMS, stated that the doors are locked at all times and when a code is punched into the keypad the door lock is released and an alarm sounds when the door is open alerting staff. The EMS indicated that the way the facility knows the doors were functioning properly is when they hear the alarm. The EMS confirmed there was no process in place to regularly monitor the Mag Lock (Key Pad) doors to ensure that they function properly. Per interview on 9/26/11 at 2:15 PM, the Administrator confirmed that there was</p>	F 456		
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F 456	Continued From page 4 no policy and procedure for the routine checking and monitoring of the Mag Lock (Key Pad) doors to ensure they function properly. Per interview on 9/30/11 at 12:30 PM with the manufacturer of the Mag Lock (Key Pad) alarm supplied to the facility the manufacturer confirmed their recommendations for this alarm system supplied to the facility with installation is that the alarms be tested on a weekly basis to ensure functionality and whenever any electrical or construction work is done.	F 456		