

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

February 10, 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 **January 7, 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

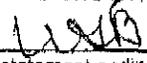
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>475033 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>01/07/2015 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>CRESCENT MANOR CARE CTRS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>312 CRESCENT BLVD<br>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 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 225<br>SS=D      | <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)<br/>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated</p> | F 225         | <p>F225</p> <ol style="list-style-type: none"> <li>1. Resident # 87 had no negative effects as a result of this alleged deficient practice.</li> <li>2. All residents have the potential to be affected by this alleged deficient practice.</li> <li>3. Staff have been re-educated on the policy of reporting all alleged violations immediately in accordance with state law.</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 February 1, 2015.</li> </ol> |                      |

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|--|--------------|----------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br> | TITLE<br>NHA | (X6) DATE<br>1.29.15 |
|--|--------------|----------------------|

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 225  | Continued From page 1<br>representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to report an allegation of inappropriate physical contact between residents for 1 of 26 residents in the Stage 2 sample, Resident #87. Findings include:<br><br>During review of the admission record for Resident #87, it was noted that a nurse progress note dated 12/6/14, written at 7:00 PM, indicated, Resident #87 may have been touched inappropriately by another resident. S/he is placed on q (every) 15 min (minute) checks and appropriate staff are notified. Per interview with the Licensed Practical Nurse (LPN) who was the on call supervisor at that time, s/he did not get the information regarding an alleged incident until 12/6/14. Per interview with the DON on 1/6/15 at 3:05 PM, the incident was not reported to her until 12/6/14 and the incident allegedly occurred on 12/5/14. Per DON the incident was investigated by the facility and it was not felt that it was a reportable incident to the State Agency secondary to the fact that during the interviews and through statements from Resident #87, there were inconsistencies and the facility did not feel that the incident had actually occurred. | F 225  | <i>F225 POC accepted 2/6/15 mtg ms rpl pnc</i>  |  |
| F 279<br>SS=D  | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  | F 279  |   |  |

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| F 279  | Continued From page 2<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>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.<br><br>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).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview and record review, the facility failed to develop a plan of care for self administration of medications for 1 or 26 residents in the Stage 2 sample, Resident #54. Findings include:<br><br>During interview with Resident #54 on 1/5/15 at 1:47 PM, it was observed that s/he took medication that was on the overbed table in front of him/her. This surveyor asked what it was that was being taken s/he stated, "my two Tramadol". Resident #54 continued to state that the medications are left by the nurse so s/he can take them when ready. Per observation during. | F 279  | F279<br><br>1. Resident #54 care plan has been revised to include self-administration of medications.<br>2. Residents who are able to self-administer medications can be affected as a result of this alleged deficient practice.<br>3. Residents that are identified as to being able to self-administer medications will be care planned for that performance. Staff will be in-serviced on the policy and procedure for self-administration of medications and timeliness.<br>4. Audits are ongoing to to assure compliance. Results will be reported to the QAPI committee by the DNS for 3 months.<br>5. Corrective action completed February 1, 2015<br><br>F279 POC accepted 2/6/15 mtg qmwrn/pme |                      |  |

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 OMB NO. 0938-0391

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| F 279  | Continued From page 3<br>medication administration on 1/5/15 at 3:56 PM, it was observed that the Licensed Practical Nurse (LPN), Unit Manager, prepared the medications, took them to the resident's room and left the medications at the bedside for Resident #54. S/he stated that Tramadol 50 mg (2 tabs) and Ferrous Sulfate 325 mg were left at the bedside. Interview with the LPN at this time confirmed that the medications are left at the bedside and the resident takes them generally within 1 hour of receiving them. The LPN stated that her Tramadol is given four times a day at 7 AM, 12 Noon, 4 PM and 8 PM. When presented with the observation that this surveyor had observed a dose of Tramadol taken at 1:47 PM, s/he said that it is unusual that it was not taken sooner by the resident. The LPN stated that the nurses will return to see if the resident has taken the medication. The physician order is 'may leave single dose medication at bedside' and per interview with LPN, single dose medication means each medication that is given within the same time frame. Confirmation was made by the Unit Manager, that there is no evidence of a care plan involving self administration of medications for Resident #54 and that s/he cannot confirm how the other staff administering the medications are checking to see that the resident has taken the medication and the time it was taken. | F 279  |   |                      |  |
| F 334<br>SS=E  | 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS<br><br>The facility must develop policies and procedures that ensure that –<br>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the   | F 334  |   |                      |  |

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| F 334   | Continued From page 4<br>immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>The facility must develop policies and procedures that ensure that --<br>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following: | F 334   | F334<br><br>1. Residents #23, 50, 54 or 57 had no negative effects as a result of this alleged deficient practice.<br>2. All residents who receive the influenza vaccine have the potential to be affected by this alleged deficient practice.<br>3. Policy and Procedure has been revised to ensure that each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization. Staff have received education regarding the requirements for education and consent, related to the influenza vaccine.<br>4. Audits will occur to assure compliance. Results will be reported to the QAPI committee by the SDC.<br>5. Corrective action completed February 1, 2015. |                      |   |

F334 POC accepted 2/6/15 mth/qms R/pmc

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| F 334  | <p>Continued From page 5</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on staff interview and record review, the facility failed to provide evidence that informed consents for the administration of Influenza vaccine to 4 of 5 residents reviewed, Resident #23, 50, 54 and 87, were present. Findings include:</p> <p>During record review, it was found that there was no evidence in the medical record that informed consents were obtained from Resident #23, 50, 54 or 87 prior to the administration of the influenza vaccination per requirements. Interview with the Infection Control Nurse on 1/8/15 at 9:28 AM confirmed that evidence of the current influenza vaccination information and a signed consent was not present in the medical records nor in facility records. S/he also stated that the facility practice is that the resident or family signs</p> | F 334  |   |                      |  |

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| F 334  | Continued From page 6<br>the informed consent only once and it is carried over from year to year.                      | F 334  |   |  |