



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

December 14, 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 annual survey conducted on November 17, 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 black ink, appearing to read "Pamela M. Cota". The signature is written in a cursive, flowing style.

Pamela M. Cota, RN
Licensing Chief



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

RECEIVED
Division of
LICENSING AND PROTECTION

PRINTED: 11/30/2010
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 _____	Licensing and Protection 11/17/2010
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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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F 000	INITIAL COMMENTS	F 000		
F 272 SS=D	<p>The Division of Licensing and Protection conducted an unannounced onsite annual recertification survey in conjunction with two complaint investigations from 11/15/10 - 11/17/10. The following deficiencies have resulted from the recertification survey.</p> <p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p>	F 272		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Charlotta Wernu Berman

Adm.

12-8-10

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 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, facility staff failed to reassess 1 applicable resident in the stage 2 sample who experienced an unplanned weight loss. (Resident #40) Findings include: Per review of current weight logs and confirmed during interview with the Clinical Registered Nurse Coordinator (RN) on 11/16/10, Resident # 40 lost a total of 6.1 lbs. between 10/25/10 and 11/6/10 (from 132.6 lbs. to 126.2 lbs.). The log documented the resident's weight as down to 124.8 on 11/12/10. The facility's policy "Weight Assessment Monitoring" states "If a resident loses/gains 3 or more pounds since their last weight, a reweigh is obtained by nursing within 48 hours and is documented on the Weight Change Form. The RN or LPN reports any confirmed weight loss to the RD, Nurse Manager, MDS Nurse, physician and family. The RD will perform an assessment of weight loss/gain, will review the care plan and make changes as needed." Per interview during the morning of 11/16/10, the Clinical Coordinator confirmed that staff were not aware of the weight loss, failed to obtain a reweigh within 48 hours and failed to reassess, per facility policy.	F 272	F272 Comprehensive Assessment Resident #40 remains in the facility in stable condition. Assistant Director of Nursing will re-educated the staff of the importance of keeping accurate weight logs. To assure compliance with facility policy of recognizing weight loss or gain. Random audits will be completed to assure compliance. These audits will be done by Nursing Administration and outcomes will be submitted to the CQI committee. Random audits will be completed quarterly to assure on-going compliance	12/17/10	
F 280 SS=D	Refer also to F280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280			

*F272 POC Accepted 12/13/10
R.Tremblay RN / Amstar RN*

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F 280	<p>Continued From page 2</p> <p>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 assure that the care plan for 1 of 37 residents in the Stage 2 sample was revised to reflect the resident's identified needs. (Resident #40) findings include:</p> <p>Per review of Resident #40's care plan on 11/16/10, the problem of risk for, and actual weight loss was not identified. The care plan goal, updated on 11/10/10 by the MDS Nurse stated, "will maintain weight at 137 + or - 3 lbs". The current weight log documented the resident's weight on 11/6/10 as 128.4 lbs. The weight on 10/25/10 was documented as 132.6, both weights well below the stated goal weight of the care plan. The failure to revise the care plan was confirmed during interviews with the MDS Nurse and the Clinical Coordinator on the morning of 11/17/10.</p>	F 280	<p>F280</p> <p>Right to Participate Planning Care-Revise CP</p> <p>Resident # 40 remains in the facility in stable condition.</p> <p>All care plans and MDS will be updated as per policy to include at risk for or actual weight loss/gain. Director of Nursing will re-educated MDS staff and will audit Care Plans to assure compliance. Audits will be presented to the CQI committee; Random audits will be submitted quarter to assure on-going compliance.</p> <p><i>F280 POC Accepted 12/13/10 R. Tremblay RN / P. MONTARN</i></p>	12/17/10

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F 280	Continued From page 3	F 280		
F 282 SS=D	<p>Refer also to F272</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 on observation, interview and record review, the facility failed to provide care and services in accordance with the plan of care for 2 of 37 residents in the sample (Residents #101, # 40). Findings include:</p> <p>1. Per record review, Resident #101's care plan related to risk for falls and injury included an intervention for a mat to be placed next to the bed on the right side. Per observation on 11/16/10 at 4:00 PM, a mat was not placed on the floor on the right side of the bed when Resident #101 was lying in the bed. In addition, a mat placed next to the bed on the left side was covered with multiple items which would make it difficult for the resident to exit the bed on the left side. The following items were observed sitting on the mat on the left side of the bed: an empty box, stuffed animals and books stacked upon of a box filled with clothes, a packed suitcase, and a bag of Pull-Up briefs. On 11/16/10 at 4:11 PM, the evening supervisor verified that a mat was not placed on right side of bed and the resident would have difficulty getting out of bed on the left side due the following items sitting on the mat: an empty box, stuffed animals and books stacked upon of a box</p>	F 282	<p>F282</p> <p>Services by Qualified Person/per Care Plan</p> <p>Resident's #101 and #40 remain in the facility in stable condition.</p> <p>Resident #101 moves her mat as she re-arranges items in her room. The room was tidy and two mats now are in her at bedside. CarePlan reflects change.</p> <p>On-going environmental rounds will be completed with staff focusing on safety issues. The nurse manager will complete audits on all Fall prevention items. Outcome will be submitted at the CQI committee. Audits will be completed for three months then quarterly to assure compliance.</p>	12/17/10

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F 282	Continued From page 4 filled with clothes, a packed suitcase, and a bag of Pull-Up briefs. 2. Per record reviews and confirmed during staff interview on 11/17/10, Resident #40 did not have weekly weights recorded as directed by the current care plan. The weight log for the period 7/5/10 to the present (11/17/10) included no weights recorded from 7/21/10 - 8/18/10, 8/25/10 - 9/11/10 and 10/25/10 - 11/6/10. During interview at 10:45 AM on 11/17/10, the Clinical Coordinator confirmed the lack of documented weekly weights.	F 282	Assistant Director of Nursing will re-educate the staff of the importance of keeping accurate weight logs. To assure compliance with facility policy of recognizing weight loss or gain. Random audits will be completed to assure compliance. These audits will be done by Nursing Administration and outcomes will be submitted to the CQI committee. Random audits will be completed quarterly to assure on-going compliance		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.		F282 POC Accepted 12/13/10 R.Tremblay RN P.Montarn	12/17/10	

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F 329	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that there were adequate indications for use for prescribed medications for 2 of 10 residents in the applicable sample. (Residents # 50 & #40). Findings include. 1. Per record review on 11/16/10 at 4:10 PM, there is a physician's order for Resident #50, dated 1/18/10, for Keppra (an anti-seizure medication) 500 mg by mouth twice a day with no related diagnosis or indication for it's use. On 11/16/10 at 4:36 PM, the Nurse Educator and the Unit Manager confirmed that there was no diagnosis or indication for Keppra in the clinical record and stated they were unsure why the resident was receiving the medication. 2. Per record review on 11/17/10, Resident #40 had physician orders for the medication Proscar (for treatment of an enlarged prostate) with no diagnosis or indication for use noted in the medical record. The lack of diagnosis and indication for use was verified with the Clinical Coordinator at 10:55 AM the same day.	F 329	F329 Drug Regimen is free from unnecessary drugs. Resident's #50 and #40 remain in the facility in stable condition. Nurses will be re-educated on the importance of obtaining diagnosis for all medication. To assure compliance the Assistant Director of Nursing and the North Nurse Manager will complete thorough audits of medication having adequate indication for use for specific drugs. On-going the Assistant Director of Nursing and North Nurse Manger will review medications and verify DX at admission and during Care Plan meetings Audit outcomes will be presented to the CQI committee two months then quarterly by Director of Nursing.	12/23/10
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431	<i>F329 POC Accepted 12/13/10 R. Tremblay RN / P. Mastaren</i>	

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F 431	<p>Continued From page 6 reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to properly store refrigerated medications. Findings include:</p> <p>1. Per observation on 11/17/2010 at 10:20 AM, the Southwest Unit Medication storage room medication refrigerator contained one individual dose of injectable Aranesp which had an expiration date of 9/11/2010. This was confirmed</p>	F 431	<p>F431</p> <p>Drug Records, Label/Store Drugs & Biological</p> <p>Temperature logs have been update to ease the use of documenting temperatures in the refrigerators. Random audits will be completed by the Nurse Manager on the North Unit and the Assistant Director of Nursing to assure proper temps. Outcomes of the audit will be presented to the CQI committee. Assistant Director of Nursing presented the updated form to all nursing staff.</p> <p>Director of Nursing and the Assistant Director of Nursing have re-educated the staff of the importance of checking medications for expiration dates. Random audits will be completed by Nursing Administration and reported to the CQI committee. These audits will be on-going to assure compliance.</p> <p><i>F431 POC Accepted 12/13/10 R. Tremblay RN / P. Mott RN</i></p>	12/17/19	

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F 431	Continued From page 7 by the Director of Clinical Services at 10:20 AM on 11/17/2010. 2. Per observation and documentation review on 11/17/10, the North Unit Medication storage room medication refrigerator was outside accepted temperature parameters on two days with a temperature of 30 degrees Farenheit (F) on 11/01/2010 and 32 degrees F on 11/02/2010. The refrigerator contained vials of Novolin Insulin for 2 residents and 4 vials of Pneumovax individual dose Vaccines, all of which should be stored at 36-46 degrees F per manufacturer's instructions. This was confirmed by the Unit Manager at 10:55 AM on 11/17/2010. 3. Per observation and documentation review on 11/17/10, the temperature log for the North Unit Medication storage refrigerator was missing entries on 9 days in October 2010, 8 days in September 2010, 2 days in August 2010, and 4 days in July 2010. This was confirmed by the Unit Manager on the morning of 11/17/2010. 4. Per observation and documentation review on 11/17/10, the Southwest Unit Medication refrigerator temperature log was missing entries on 9 days in October 2010, 8 days in September 2010, 13 days in August 2010, and 13 days in July 2010. This was confirmed by the Director of Clinical Services on the morning of 11/17/2010.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		

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F 441	Continued From page 8 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility staff failed to provide a safe, sanitary environment to help prevent the development and transmission of disease regarding medication administration and storage	F 441	F441 Infection Control, Prevent Spread, Linens Resident #104 and #14 remain in the facility in stable condition. Assistant Director of Nursing re-educated the nursing staff the importance of wearing gloves during medication administration. Routine audits will be completed by Assistant Director of Nursing to assure compliance. Outcomes will be presented to CQI committee. On-going environmental rounds will be completed with staff focusing on infection control issues. The nurse manager will complete audits on all resident rooms to assure compliance. Outcomes will be reported to the CQI Committee by the ADNS for three months then quarterly to assure compliance. <i>F441 POC Accepted 12/13/10 R.Tremblay RN / P.Mcota RN</i>	12/17/10

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F 441	<p>Continued From page 9</p> <p>of resident equipment for 2 of 41 residents in the sample (Resident #104 and #42). Findings include:</p> <p>1. Per observation on 11/17/10 at 7:43 AM, a staff nurse failed to wear gloves while administering medications to Resident #104 during a medication pass. The nurse administered Fortical, a nasal spray, and subcutaneous Novolin N insulin without wearing gloves. Per interview with the facility Nurse Educator on 11/17/10 at 8:22 AM, it is his/her expectation that staff wear gloves when administering a nasal medication. Per review of facility policy on 11/17/10 at 8:24 AM, staff are to wear gloves when administering a subcutaneous medication. Per interview with the nurse who administered the medications on 11/17/10 at 8:28 AM s/he confirmed that s/he was not wearing gloves while administering the nasal and subcutaneous medications.</p> <p>2. Per observations in the bathroom for Resident #42 at 12:15 PM on 11/15/10 and 9 AM and 3:30 PM on 11/16/10, a bed pan was stored directly on the floor under the sink. During the 3:30 PM observation on 11/16/10, the Clinical Coordinator and the assigned LNA (Licensed Nursing Assistant) were both present with the surveyor and agreed the bed pan should not have been stored there and it was immediately removed and disposed of.</p>	F 441		