

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

August 12, 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 **July 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



AUG 10 11

Licensing and  
Protection

PRINTED: 08/03/2011  
FORM APPROVED  
OMB NO. 0938-0391

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  07/27/2011
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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  The Division of Licensing and Protection conducted an unannounced on-site annual recertification survey from 7/25/11 to 7/27/11. The following regulatory deficiencies were identified:  F 156 SS=C 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES  The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.  The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.  The facility must inform each resident before, or at the time of admission, and periodically during	F 000  F 156	F156 During Survey poster was updated with appropriate agencies and contact information.  Administrator will routinely check to assure accuracy of information on a monthly basis. Yearly, Administrator will report to CQI that the information is accurate.  7/26/11 F156 P.O.C. Accepted 8/11/11 P.Cummings RN / P.Motaran	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Charles Waver Doon</i>	TITLE <i>Adm</i>	(X6) DATE 8-9-11
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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 156	<p>Continued From page 1</p> <p>the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter</p>	F 156		

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F 156

Continued From page 2

related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:  
Based on observation and interview, the facility failed to prominently display written information about how to apply for or use Medicare and Medicaid benefits and information about the Medicaid Fraud Unit.

On 7/25/2011 at 11:30 am, posting of resident rights and other pertinent information were found on the bulletin board outside the administrative offices. The information concerning Medicaid was outdated and also did not include how to apply for Medicaid including the address and

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F 156	Continued From page 3 telephone number, and the Medicaid Fraud Unit. Also, there was no information as to how to apply for Medicare. On 7/25/11 at 2:00 PM, the Administrator confirmed that these items were not posted.	F 156		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  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.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the resident environment remains as free of accident hazards as possible. Findings include:  Per observation of the west unit central bathing room on 7/27/11 at 9:21 A.M., there were several plugged in electrical devices with cords dangling from an approximately 5 inch wide shelf situated over a toilet, creating a potential accident hazard. The Unit Manager and a Licensed Nursing Assistant confirmed at the the time of the observation that the devices were used by residents routinely and that the dangling cords presented an accident hazard.	F 323	<b>F323</b> Prior to exit the electrical devices were removed. The shelf was also removed. The practice of having these items in the shower room has been discontinued.  Nurse Manager will routinely check to assure compliance and that no other electrical equipment is placed in the shower room. Audits for the next 60 days will be completed and presented to the CQI committee to assure compliance.  SDC will re-educate staff as to proper storage of these items and the potential risk of having these items in the shower room.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from	F 329		

8/19/11  
F323 P.O.C. Accepted 8/11/11  
P.Cummings RN / Pincotarn

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F 329	<p>Continued From page 4</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that the medication regime for 1 of 19 residents (Resident # 80) had adequate indications for use for 1 medication. Findings include:</p> <p>Per medical record review on 07/27/2011 at 8:18 AM, there is no indication for the use of Symmetrel for Resident # 80 in the history and physical, on the problem list or on the Medication Administration Record (MAR). Symmetrel is used</p>	F 329	<p><b>F329</b></p> <p>Resident #80 remains in the facility in stable condition.</p> <p>Physician was contacted and diagnosis was obtained. Nurse Managers are responsible to review all medications to assure diagnosis is present to support their use.</p> <p>Audits will be completed for the next 60 days to assure compliance. Random audits will be completed monthly by Nurse Manager's to assure on-going compliance and outcomes will be reported at CQI meeting.</p> <p>8/19/11 On-going</p> <p><i>F329 P.O.C. Accepted 8/11/11 P-Cummings RN / P-Mcota RN</i></p>

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F 329	Continued From page 5 primarily to treat symptoms of Parkinson's disease. This medication had been ordered prior to 01/01/2011. Staff confirms during interview on 07/27/2011 at 10:18 AM, that no indication for the use of Symmetrel is provided anywhere in the medical record and that the expectation of the facility is that all medications will have a diagnosis to support their use.	F 329			
F 356 SS=C	Also see F428. 483.30(e) POSTED NURSE STAFFING INFORMATION  The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.  The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.  The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356			

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F 356	Continued From page 6  The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the nurse staffing information, including registered nurses, licensed practical nurses, and licensed nursing assistants and the total resident census.  On 7/25/2011 at 11:30 AM, the nurse staffing information could not be found posted in the facility. Interview with the Administrator on 7/25/2011 at 2:00 PM confirmed that they did not post the nurse staffing information as required.	F 356	<b>F356</b> Prior to exit nursing hours were posted.  Director of Nursing will check daily that nursing hours are posted in the proper format. Outcomes will be reported to the CQI committee for the next 60 days to assure compliance.  7/26/11 <i>F356 P.O.C. Accepted 8/11/11 P.CummingsRN / PincotARN</i>	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure that the medication regime for 1	F 428		

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F 428	Continued From page 7 of 19 residents (Resident # 80) had adequate indications for use for 1 medication. The facility further failed to assure that the pharmacist reported this irregularity to the attending physician. Findings include:  Per medical record review on 07/27/2011 at 8:18 AM there is no indication for the use of Symmetrel for Resident # 80 in the history and physical, on the problem list or on the Medication Administration Record (MAR). Symmetrel is used primarily to treat symptoms of Parkinson's Disease. This medication had been ordered prior to 01/01/2011. Staff confirms during interview on 07/27/2011 at 10:18 AM that no indication for the use of Symmetrel is provided anywhere in the medical record and that the expectation of the facility is that all medications will have a diagnosis to support their use.  Per record review on 07/27/2011 at 8:18 AM the required monthly pharmacy consults have been documented as having been done from January 2011 through 7/25/2011. There is no evidence to support that a missing diagnosis was identified by the pharmacist for the use of Symmetrel for Resident # 80. There is no documentation to indicate that the physician was notified of the missing indication for the use of Symmetrel.	F 428	<b>F428</b>  Resident #80 remains in the facility in stable condition.  Physician was contacted and diagnosis was obtained. Nurse Managers are responsible to review all medications to assure diagnosis is present to support their use.  Audits will be completed for the next 60 days to assure compliance. Outcomes will be reviewed at monthly CQI meeting. Random audits will be completed monthly by Nurse Managers to assure on-going compliance and outcomes will be reported at CQI meeting.  Pharmacist was contacted regarding this issue. DNS will review Pharmacist monthly report to assure no discrepancies are present.		
F 441 SS=E	Also see F329. 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	F 441	8/19/11 On-going  F428 P.O.C. Accepted 8/11/11 P. Cummings RN / P. Mcota RN		

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F 441	<p>Continued From page 8 of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <ol style="list-style-type: none"> <li>(1) Investigates, controls, and prevents infections in the facility;</li> <li>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</li> <li>(3) Maintains a record of incidents and corrective actions related to infections.</li> </ol> <p>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> <li>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</li> <li>(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.</li> <li>(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.</li> </ol> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon observation, interview and record review, the facility failed to establish and maintain an Infection Control Program designed to provide</p>	F 441		
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F 441	<p>Continued From page 9</p> <p>a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection per observations including: a pressure ulcer dressing change for one resident in the applicable Stage 2 sample (Resident #1); dining observations; and during environmental rounds. Findings include:</p> <ol style="list-style-type: none"> <li>1. Per observation of Resident #1's left foot pressure ulcer dressing change on 7/27/11, and confirmed during interview on 7/27/11 at 9:50 AM, Nurse #1 dropped the television remote on the floor prior to the dressing change, picked up the remote from the floor, and failed to wash or sanitize hands prior to laying out a clean barrier and placing a saline wound flush on the barrier. The Surveyor stopped the dressing change before Nurse #1 opened non-sterile gauze on the barrier. Per interview with the Director of Nursing (DNS) and review of the Infection Control Reminder and Procedure for Clean Dressing Technique on 7/27/11 at 10:45 AM, the DNS confirmed that Nurse #1 should have washed or sanitized hands after picking up the remote from the floor prior to laying out a clean barrier and dressing supplies.</li> <li>2. Per observation and staff interviews, an LNA was observed on 07/25/2011 at 11:45 AM feeding two residents at a time without sanitizing hands between direct contact. The LNA was observed feeding food and drink, wiping mouths and hands, and repositioning residents during feeding without sanitizing or washing hands. S/he stated in an interview at 12:10 PM on 07/25/2011 that s/he would not sanitize hands between feeding two residents but s/he washed her/his hands before beginning to feed residents and when finished</li> </ol>	F 441		
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F 441	<p>Continued From page 10</p> <p>feeding residents. In an interview at 12:20 PM on 07/25/2011 the Unit Manager stated that it is expected that, when feeding two residents, a staff member would feed several bites, sanitize hands and feed the second resident several bites, sanitizing hands each time s/he moved to a different resident.</p> <p>3. Per observation of the noon meal on 7/25/11 at 12:22 P.M. in the north Unit dining room, staff failed to sanitize hands between direct resident contact while assisting with feeding. A Licensed Nursing Assistant (LNA) picked up a slice of bread with bare hands, touched a resident's hand then answered the telephone before proceeding to assist feeding another resident, touching that resident's cheeks when putting on a clothing protector. At 12:37 P.M., the same LNA picked up a resident's sandwich with bare hands and assisted the resident by touching his/her hand and guiding the sandwich to his/her mouth. The LNA then picked up another resident's cup by the upper 1/2 inch of the rim and gave it to the resident to drink. The LNA did not sanitize his/her hands between any of the aforementioned observations. At 12:45 P.M. on 7/25/11, the LNA confirmed that s/he did not sanitize hands between direct resident contact as observed above. On 7/27/11 at 9:51 A.M., the Unit Manager (UM) stated that staff should be sanitizing hands between resident contact while feeding residents.</p> <p>4. Per observation on 7/25/11 at 12:21 PM in the North Unit dining room, a feeding assistant was observed to be touching a resident tray and then using unsanitized, ungloved hands to pick up and butter a slice of bread and then handing the</p>	F 441	<p><b>F441</b></p> <p>Resident #1 remains in the facility in stable condition.</p> <p><b>#1</b></p> <p>Staff Development re-educated all nursing staff on proper aseptic techniques. Nurse Manger and SDC will be completing random visual audits of dressing changes to assure proper techniques are maintained. Outcomes of audits will be presented at CQI meetings. Random Audits will be completed over the next 60 days.</p> <p><b>#2</b></p> <p>SDC re-educated all nursing staff and feeders on proper procedures for sanitizing hands while feeding. Random visual audits will be completed by SDC and Nurse Managers to assure compliance.</p> <p><b>#3</b></p> <p>SDC re-educated all nursing staff and feeders on proper procedures for sanitizing hands while feeding. Random visual audits will be completed by SDC and Nurse Managers to assure compliance.</p>		

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:  475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/27/2011
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 441	Continued From page 11 bread to the resident. During an interview with the feeding assistant on 7/25/11 at 1:00 PM, s/he confirmed that s/he should be sanitizing or washing hands in between touching non food items and then touching food items and that s/he had forgotten to do this. In an interview on 7/27/11 at 10:07 AM with the infection control nurse, s/he indicated that the expectation of staff assisting residents in the dining area is that they observe infection control techniques by washing, gloving or sanitizing hands between contact with non food surfaces and consumable items.  5. Per observation during the environmental tour on 7/27/11 at 9:12 AM, two unlabeled electric hair trimmers, one electric razor and a curling iron were observed on the shelf in the West Unit central bathroom. One hair trimmer had a rusty blade and both hair trimmers and the electric razor were observed to be encrusted with hair clippings. The curling iron barrel was noted to be caked with a dark brown crust containing old hair and what appeared to be burnt hair product. The shelving that the trimmers and curling iron were located on was noted to be coated with hair trimmings and old hair product drippings. In interview with a Licensed Nursing Assistant from the unit s/he confirmed the trimmers, razor and curling iron were being used daily on residents. The Unit Manager confirmed on 7/27/11 at 9:21 AM that his/her expectation is that the trimmers and razor be cleaned after each use and all appliances were to be individually labeled for each resident.	F 441	#4 SDC re-educated all nursing staff and feeders on proper procedures for sanitizing hands while feeding. Random visual audits will be completed by SDC and Nurse Mangers to assure compliance.  #1, 2, 3, 4 audit outcomes will be reported to the CQI committee to assure on-going compliance.  8/19/11 On-going  #5 All items were removed and disinfected and labeled prior to exit and placed in individual rooms.  Nurse Manger will randomly audit all personal care equipment to assure compliance. Outcomes will be reported to CQI committee.  8/19/11 On-going  F441 P.O.C. Accepted 8/11/11 P. Cummings RN / Pincot RN	
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION  The facility must maintain all essential	F 456		

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F 456	<p>Continued From page 12 mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain the oxygen concentrator filter for 1 of 5 residents using oxygen concentrators (Resident #9).</p> <p>On all days of survey, the cooling air intake filter for the oxygen concentrator being used by Resident #9 was covered with heavy white dust. On 7/27/2011 at 11:00 AM, the resident was observed sleeping in bed using the oxygen concentrator. On 7/27/2011 at 11:30 AM, the Facilities Director stated that the housekeepers were responsible for keeping the filters clean and it was done monthly. The manufacturer's recommendation for routine maintenance of the oxygen concentrator to ensure accurate output and efficient operation of the unit included the cleaning of the filter on a weekly basis and may require daily cleaning if it operates in a harsh environment.</p>	F 456	<p><b>F456</b> All Concentrators were checked for cleanliness of filters. Environmental Director will change the filter cleaning schedule from monthly to weekly to assure compliance. Audits will be completed by Environmental Director to assure compliance, Outcomes will be reported to CQI Committee.</p> <p>8/19/11 On-going</p> <p><i>F456 P.D.C. Accepted 8/11/11 P. Cummings RN / Pincotarn</i></p>	
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