

Division of Licensing and Protection
103 South Main Street, Ladd Hall
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

October 16, 2012

Ms. Claudette Werner-Poorman, Administrator
Crescent Manor Care Ctrs
312 Crescent Blvd
Bennington, VT 05201-0170

Dear Ms. Werner-Poorman:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 12, 2012**. 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

RECEIVED
Division of
Licensing and
Protection
PRINTED: 09/26/2012
FORM APPROVED
OMB NO. 0938-0391

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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 C 09/12/2012 |
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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 | INITIAL COMMENTS | F 000 | | |
| F 241 SS=D | <p>An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 9/12/12. Based on the investigation, a deficiency was identified.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to promote care for one resident [Resident #1] in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Findings include: 1). Per observation on 9/12/12 at 11:45 A.M. in the facility's North Unit dining room, Resident #1, whose diagnoses include dementia, anxiety, dysphagia [difficulty in swallowing], and convulsions, was seated in a reclining 'geri-chair' with an attached tray, facing a television, with h/her back to the other 13 residents in the dining room. Per observation at 12:02 P.M. meal trays arrived at the dining room from the kitchen and were distributed to all the residents except for Resident #1 by 12:14 P.M.. Per observation at 12:22 P.M., 37 minutes after the dining observation began, an LNA [Licensed Nursing Assistant] placed a tray with a plate containing a 'sloppy joe' and one drink in front of Resident #1</p> | F 241 | <p>F241</p> <p>Resident #1 remains in the facility in stable condition.</p> <p>Care Plan was updated stating resident will eat in the assisted dining room, with detailed Plan of Care related to stimulus and assistance required.</p> <p>SDC completed in-service on Residents Rights which include dignity and respect.</p> <p>Nurse Manager will complete audit to assure compliance, outcomes will be presented to CQI Committee. These audits will be completed for the next three months. If compliance is not achieved to the satisfaction of the Administrator, audits will continue.</p> <p>In-Service will be completed by SDC to include the importance of assisting residents as needed to assure adequate nutrition.</p> | <p>9/13/12</p> <p>9/25/12</p> <p>10/8/12 Ongoing</p> <p>10/10/12</p> |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Cherette Werner - Poorn* TITLE: *Adm* (X6) DATE: *10-3-12*

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.

Pmc

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| F 241 | <p>Continued From page 1 and walked away. At this time there were 4 LNAs assisting 14 residents in the dining room. Per observation, Resident #1 picked at the sloppy joe and placed bits of meat into h/her drink.</p> <p>At 12:34 P.M. a second LNA [#2] asked Resident #1 "are you eating over there?". There was no physical or verbal response from Resident #1. Per observation at 12:56 P.M., 34 minutes after having the meal tray placed in front of Resident #1, Resident #1 still had h/her hands in their food. LNA #2 walked over and said 'hello' to Resident #1 and walked away. There was no response from Resident #1. At this time there were 5 aides assisting 16 other residents in the dining room. Per observation at 1:00 P.M. a third LNA [#3] asked Resident #1 "Are you finished eating?" There was no response from Resident #1. LNA #3 removed the food tray from in front of Resident #1. Per interview with LNA #3 on 9/12/12 at 1:16 P.M. Resident #1 did not respond to any questions or cues regarding eating or drinking during the 9/12/12 Lunch meal.</p> <p>Per observation Resident #1 had not taken a bite from h/her meal or taken a sip from h/her drink during the time h/she had a meal tray before them. At 1:15 P.M., approximately 1 1/2 hours after Resident #1 was observed in the activities/dining room awaiting lunch, Resident #1 was wheeled out of the room by a LNA without having eaten or having drank anything. Per record review on 9/12/12 at 1:30 P.M., the Meal Percentage Sheet for lunch [where LNAs record the amount eaten by each resident] records Resident #1 as having 'refused' to eat or drink any of h/her lunch. Per interview at 1:16 P.M. on 9/12/12 with 3 of the LNAs present during Lunch,</p> | F 241 | <p>Nurse Manager will complete audits to assure compliance, outcomes will be presented to CQI Committee. These audits will be completed for the next three months. If compliance is not achieved to the satisfaction of the Administrator, audits will continue</p> <p>SDC will re-educate Nursing Staff on the importance of maintaining accurate documentation on Behaviors.</p> <p>Nurse Manager will audit Behavior Monitoring sheet to assure compliance, outcomes will be presented to CQI Committee. These audits will be completed for the next three months. If compliance is not achieved to the satisfaction of the Administrator, audits will continue.</p> <p><i>F241 POC accepted 10/14/12 TDougherty RN/PMC</i></p> | 10/8/12 Ongoing | 10/10/12 Ongoing |

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| F 241 | <p>Continued From page 2</p> <p>the LNAs stated Resident #1 "feeds [h/her] self. Sometimes [h/she] eats, sometimes [h/she] doesn't. Sometimes [h/she] will throw the food off the tray". Per record review of Resident #1's Behavior Monitor Sheet for September 2012, possible behaviors listed include: constant foul language, hitting, biting, & pinching. The Behavior Monitor sheet for September 2012 shows no incidents of behaviors recorded thru 9/12/12, the day of the investigation.</p> <p>Per interview with Day Shift Nurse #1, Evening Nurse #1, and the facility's Director of Nursing [DON] at 2:05 P.M. on 9/12/12 Resident #1 "sometimes eats, sometimes responds; [h/sh]e has good days and bad days. [Resident #1] feeds [h/herself]." Per record review of Resident #1's Nutrition Risk Assessment dated 4/3/12, Resident #1 requires "assistance, supervision while eating". Notes from the assessment read Resident #1 is "dependently fed either in feeder dining room by staff or by husband in activities/dining room". Per record review of the Nutrition Quarterly Review, dated 7/2/12 Resident #1 requires "extensive feeding assistance". Per record review of the Nursing Notes Weekly Progress Reports for 8/15/12, 8/22/12, 8/29/12, & 9/5/12, for meals Resident #1 "requires assist".</p> <p>Per interview on 9/12/12 at 4:40 P.M., the facility's Administrator, Assistant Administrator, and the Director of Nursing confirmed that according to the facility's documentation in the Nutrition Risk Assessment, Nutrition Quarterly Review, and Nursing Notes from the previous 4 weeks Resident #1 required "extensive assistance", "assistance and supervision", or to be "dependently fed...by staff " and per the</p> | F 241 | | | |

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| F 241 | Continued From page 3 surveyor's observation during lunch on 9/12/12, confirmed by staff present in the dining room, Resident #1 was in the dining room for a minimum of 37 minutes before being given anything to eat or drink, was given h/her meal 20 minutes after it had arrived and after all other residents in the dining room were eating or being fed by staff, was offered no assistance with eating or drinking by staff, had h/her meal tray taken away without anything having been eaten, and was documented by staff as having refused food or drink. | F 241 | | |
| F 312 SS=D | See also F312. 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 applicable resident (Resident #1), who is unable to carry out activities of daily living, received the necessary services to maintain good nutrition. Findings include: 1). Per observation on 9/12/12 at 11:45 A.M. in the facility's North Unit dining room, Resident #1, whose diagnoses include dementia, anxiety, dysphagia [difficulty in swallowing], and convulsions, was seated in a reclining 'geri-chair' | F 312 | | |

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| F 312 | Continued From page 4 with an attached tray, facing a television, with h/her back to the other 13 residents in the dining room. Per observation at 12:02 P.M. meal trays arrived at the dining room from the kitchen and were distributed to all the residents except for Resident #1 by 12:14 P.M.. Per observation at 12:22 P.M., 37 minutes after the dining observation began, an LNA [Licensed Nursing Assistant] placed a tray with a plate containing a 'sloppy joe' and one drink in front of Resident #1 and walked away. At this time there were 4 LNAs assisting 14 residents in the dining room. Per observation, Resident #1 picked at the sloppy joe and placed bits of meat into h/her drink. At 12:34 P.M. a second LNA [#2] asked Resident #1 "are you eating over there?". There was no physical or verbal response from Resident #1. Per observation at 12:56 P.M., 34 minutes after having the meal tray placed in front of Resident #1, Resident #1 still had h/her hands in their food. LNA #2 walked over and said 'hello' to Resident #1 and walked away. There was no response from Resident #1. At this time there were 5 aides assisting 16 other residents in the dining room. Per observation at 1:00 P.M. a third LNA [#3] asked Resident #1 "Are you finished eating?" There was no response from Resident #1. LNA #3 removed the food tray from in front of Resident #1. Per interview with LNA #3 on 9/12/12 at 1:16 P.M. Resident #1 did not respond to any questions or cues regarding eating or drinking during the 9/12/12 Lunch meal. Per observation Resident #1 had not taken a bite from h/her meal or taken a sip from h/her drink during the time h/she had a meal tray before them. At 1:15 P.M., approximately 1 1/2 hours | F 312 | F312 Resident #1 remains in the facility in stable condition. Care Plan was updated stating resident will eat in the assisted dining room, with detailed Plan of Care related to stimulus and assistance required. SDC completed in-service on Residents Rights which include dignity and respect. Nurse Manager will complete audit to assure compliance, outcomes will be presented to CQI Committee. These audits will be completed for the next three months. If compliance is not achieved to the satisfaction of the Administrator, audits will continue. In-Service will be completed by SDC to include the importance of assisting residents as needed to assure adequate nutrition. | 9/13/12 9/25/12 10/8/12 Ongoing 10/10/12 | |

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| F 312 | <p>Continued From page 5</p> <p>after Resident #1 was observed in the activities/dining room awaiting lunch, Resident #1 was wheeled out of the room by a LNA without having eaten or having drank anything. Per record review on 9/12/12 at 1:30 P.M., the Meal Percentage Sheet for lunch [where LNAs record the amount eaten by each resident] records Resident #1 as having 'refused' to eat or drink any of h/her lunch. Per interview at 1:16 P.M. on 9/12/12 with 3 of the LNAs present during Lunch, the LNAs stated Resident #1 "feeds [h/her] self. Sometimes [h/she] eats, sometimes [h/she] doesn't. Sometimes [h/she] will throw the food off the tray". Per record review of Resident #1's Behavior Monitor Sheet for September 2012, possible behaviors listed include: constant foul language, hitting, biting, & pinching. The Behavior Monitor sheet for September 2012 shows no incidents of behaviors recorded thru 9/12/12, the day of the investigation.</p> <p>Per interview with Day Shift Nurse #1, Evening Nurse #1, and the facility's Director of Nursing [DON] at 2:05 P.M. on 9/12/12 Resident #1 "sometimes eats, sometimes responds; [h/sh]e has good days and bad days. [Resident #1] feeds [h/herself]." Per record review of Resident #1's Nutrition Risk Assessment dated 4/3/12, Resident #1 requires "assistance, supervision while eating". Notes from the assessment read Resident #1 is "dependently fed either in feeder dining room by staff or by husband in activities/dining room". Per record review of the Nutrition Quarterly Review, dated 7/2/12 Resident #1 requires "extensive feeding assistance". Per record review of the Nursing Notes Weekly Progress Reports for 8/15/12, 8/22/12, 8/29/12, & 9/5/12, for meals Resident #1 "requires assist".</p> | F 312 | <p>Nurse Manager will complete audits to assure compliance, outcomes will be presented to CQI Committee. These audits will be completed for the next three months. If compliance is not achieved to the satisfaction of the Administrator, audits will continue</p> <p>SDC will re-educate Nursing Staff on the importance of maintaining accurate documentation on Behaviors.</p> <p>Nurse Manager will audit Behavior Monitoring sheet to assure compliance, outcomes will be presented to CQI Committee. These audits will be completed for the next three months. If compliance is not achieved to the satisfaction of the Administrator, audits will continue.</p> <p><i>F312 PDC accepted 10/14/12 TDaugherty R/N/ PMC</i></p> | <p>10/8/12 Ongoing</p> <p>10/10/12 Ongoing</p> |

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| F 312 | Continued From page 6 Per interview on 9/12/12 at 4:40 P.M., the facility's Administrator, Assistant Administrator, and the Director of Nursing confirmed that according to the facility's documentation in the Nutrition Risk Assessment, Nutrition Quarterly Review, and Nursing Notes from the previous 4 weeks Resident #1 required "extensive assistance", "assistance and supervision", or to be "dependently fed...by staff" and per the surveyor's observation during lunch on 9/12/12, confirmed by staff present in the dining room, Resident #1 was in the dining room for a minimum of 37 minutes before being given anything to eat or drink, was given h/her meal 20 minutes after it had arrived and after all other residents in the dining room were eating or being fed by staff, was offered no assistance with eating or drinking by staff, had h/her meal tray taken away without anything having been eaten, and was documented by staff as having refused food or drink. See also F241. | F 312 | <i>This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Crescent Manor does not admit that the deficiencies exist, nor does the facility admit to any statement findings, facts or conclusions that form the basis by the alleged deficiency. The facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusion that form the basis for the deficiency.</i> | | |