

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

April 6, 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 **March 16, 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

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

RECEIVED PRINTED: 03/19/2015  
Division of FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ APR 15 2015 Licensing and Protection	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/16/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CRESCENT MANOR CARE CTRS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>312 CRESCENT BLVD BENNINGTON, VT 05201</b>
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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  An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 3/16/15. While the facility was found to be in substantial compliance, the following issue was found that requires correction.	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 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary and orderly interior. Findings include:  On 3/16/15 at 10:05AM while on tour with administrator, it was noted that at the end of the West Hall, there was a wheelchair (w/c) with a high back cushion that was ripped and taped together with duct tape and there was a milk crate with arm and leg protectors in it. There was also a dirty broda wheelchair, a wide seat w/c, an electric w/c and a w/c with clothes and a towel in the seat. S/he stated that s/he did not know who they belonged to. There was also a broda w/c outside room 52 and 54.  On the South wing there were 3 mechanical lifts stored on one side of the hall. Located outside rooms 30 and 26 and 24. Observation at 11:05AM presented with no change in equipment	F 253	F253  1. High back wheelchair repaired and a new replacement chair has been ordered. 2. Wheel chairs not in use will be stored in the appropriate resident room. 3. All other equipment not being utilized will be stored in the proper location. 4. Staff have been re-educated on the policy and procedure of equipment storage. 5. Audits are ongoing to to assure compliance. Results will be reported to the QAPI committee by the charge nurses for 3 months. 6. Corrective action completed March 30, 2015.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>W. Beatty</i>	TITLE <b>NHA</b>  (X6) DATE <b>3.30.15</b>
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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.

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

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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 253	<p>Continued From page 1 in the halls as indicated above.</p> <p>At 12:05PM, toured with administrator and presented that the equipment stored as indicated above had not been moved, except for one of the mechanical lifts that was outside room 24 had been used for a resident transfer and placed in hall now outside room 28. Per interview with the administrator at this time s/he stated that storage of w/c and mechanical lifts are to be in an empty resident room, but there currently are none, or in an empty bay in the shower room. Further stated that they should not be stored in the hall and the Director of Nurses had commented to administrator that that they (staff) knows better.</p>	F 253	F 253 POC accepted 4/13/15 BBA/ACP/NSJ/pml	