

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

October 8, 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 **September 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,



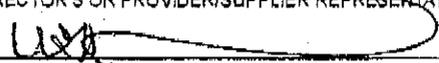
Pamela M. Cota, RN
Licensing Chief



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

PRINTED: 09/24/2015
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 _____	(X3) DATE SURVEY COMPLETED C 09/16/2015
NAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS			STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD 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 An unannounced on-site complaint investigation and a review of four self reports was conducted by the Division of Licensing and Protection from 9/14/15 through 9/16/15. There were regulatory deficiencies identified. A determination of Immediate Jeopardy to the health and safety of residents was made on 9/15/15 (Refer to findings at F281 and F323), which also constituted Substandard Quality of Care. Prior to the end of the survey, on 9/16/15, the facility successfully removed the Immediate Jeopardy, however deficient practices remain. The findings are as follows: 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	F 000	The attached 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. F225 1. Resident # 1 had no negative effects as a result of this alleged deficient practice. Resident has been discharged from this facility. 2. All residents who leave the grounds unsupervised have a potential to be affected by this alleged deficient practice. 3. Staff will be re-educated on the policy and procedure of reporting all alleged elopements immediately and accordance with state law. 4. Audits are ongoing to to assure compliance. Results will be reported to the QAPI committee by the DNS for 3 months. 5. Corrective action completed October 5, 2015. F335 POC accepted 10/7/15 mBertrandRn/pmc	
F 225 SS-E	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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 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. 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).	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
 NHA 10.5.15

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	<p>Continued From page 1</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 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and confirmed by staff interview, the facility failed to ensure that alleged violations of neglect are investigated and reported immediately. For 1 of 69 residents reviewed, numerous reports of elopements were made by community members, witnessing instances where Resident #1 was in severe danger. The findings include the following:</p> <p>Resident #1 was admitted on 7/20/15 with diagnosis to include Schizoaffective Disorder, Anxiety, Diabetes, Obesity, Chronic Obstructive Pulmonary Disease, Bilateral Cataracts, Osteoarthritis and Chronic Pain. Physician orders dated and signed on 7/17/15 prior to admission, identifies Resident #1, "No, may not leave the building on pass". This order is confirmed by Unit Manger on 9/14/15. Per medical record review, nurses notes dated at various intervals beginning on 7/20/15 through 9/14/15, evidence that the resident left the facility</p>	F 225		

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F 225	<p>Continued From page 2</p> <p>unattended on approximately 39 separate occasions. The leave of absences varied from fifteen (15) minutes to as long as seven (7) hours in duration and during the day, evening and night hours.</p> <p>7/20 through 7/24/15: Resident #1 left the facility without supervision on 5 separate occasions. The resident was seen ambulating with a walker down Crescent Boulevard, heading downtown. Neighbors called the facility to alert the missing resident.</p> <p>7/28 through 8/5/15: Resident #1 left the facility without supervision on 7 separate occasions. On 2 occasions the resident appeared in the Emergency Department (ED) for complaints of chest and left arm pain. ED treated and released the resident back to the nursing facility with instructions. Nurses documentation evidences that the resident was out of the facility unattended for durations lasting up to 7 hours.</p> <p>8/6 through 8/13/15: Resident #1 left the facility without supervision on 4 separate occasions. On one of the 4 occasions, the resident appeared at the rescue squad building partially clothed, in a T-Shirt and adult pull-ups.</p> <p>8/14 through 8/22/15: Resident #1 left the facility without supervision on 5 separate occasions. The resident appeared in the ED inappropriately dressed. Nurses documentation evidences that the resident was out of the facility unattended for durations lasting up to 5 hours.</p> <p>8/23 through 8/31/15: Resident #1 left the facility without supervision on 8 separate occasions. The two following episodes documented in the</p>	F 225		

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F 225	<p>Continued From page 3</p> <p>nurses notes evidence that lack of supervision by facility staff, that placed Resident #1 in situations of severe danger. On 8/28/15 at 5:45 AM the facility was notified by the attendant of a local Gas Station/Minimart, (at the bottom of the hill), that Resident #1, has been directing traffic on Route #7, a major highway. S/he is removing his/her clothing in the Minimart. The establishment would like the resident picked up. Nursing home staff informed Minimart staff they could not meet their request to provide transportation for the resident back to the nursing facility. On 8/28/15 at 2 PM, Resident #1 was walking in the circle/driveway in front of the facility, s/he became tired and just stopped. Oncoming vehicles were redirected and the resident was moved by facility staff to the grass where s/he rested.</p> <p>9/1 through 9/14/15: Resident #1 left the facility without supervision on 9 separate occasions. The following episode, documented in the nurses notes, evidence that lack of supervision by facility staff, that placed Resident #1 in situation of severe danger: On 9/1/15 the facility received a call reporting that Resident #1 was seen walking on the yellow line on South Street. Resident was returned to the facility by the rescue squad.</p> <p>Nurses notes identify the following: - Concerned citizens have returned the resident to the facility. - Facility staff silence alarm while resident exited the building. - Facility staff do not consistently identify when the resident leaves or returns. - On several occasions resident called the facility, taxi, EMS or Police to be returned to the facility.</p>	F 225		

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F 225	Continued From page 4 - Nurses Notes evidence that facility staff will not pick up resident when he or a local establishments request transportation. Per interview with the Nursing Home Administrator and the Director of Nurses, confirmation is made that no internal investigations have been completed on any of the above instances nor has the facility made any reports to the appropriate State agencies in accordance with State law.	F 225		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.	F 278	F278 1. Residents #1 had no negative effects from this alleged deficient practice. 2. Residents who wander can be affected as a result of this alleged deficient practice. 3. RN will verify that the information in section E 0900 of the MDS is accurate. 4. Audits are ongoing to assure compliance. Results will be reported to the QAPI committee by the DNS for 3 months. 5. Corrective action completed October 5, 2015. <i>F278 POC accepted 10/17/15 MBeckman PJP/PM</i>	

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F 278	<p>Continued From page 5</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review the facility failed to accurately assess 1 of 10 residents reviewed that reflects the residents status. For Resident #1, the findings include the following:</p> <p>Per medical record review Resident #1 was admitted on 7/20/15 with diagnosis to include Schizoaffective Disorder, Anxiety, Diabetes, Obesity, Chronic Obstructive Pulmonary Disease, Bilateral Cataracts, Osteoarthritis and Chronic Pain.</p> <p>Per admission Minimum Data Set (MDS) Assessment, a Federally mandated Assessment, completed on 7/31/15 by the Licensed Practical Nurse (LPN) and signed by the Registered Nurse (RN) Director of Nurses (DNS) identifies that Section E 0900, identifies that Resident #1 has not wandered. Care Area Assessment (CAA) documented by LPN identifies that the resident leaves the facility and does not alert staff on leaving. Wander-guard bracelet applied to wrist (security system) which alerts staff as resident attempts to leave the facility unattended.</p> <p>Nurses notes document that Resident #1 has left the facility unattended on approximately 11 occurrences from date of admission to the completion of the assessment dated 7/31/15.</p>	F 278		
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	<p>Continued From page 6</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide services that meet professional standards of quality regarding following physician orders for Resident #1, that clearly direct facility staff that the resident may not leave the building on pass. The findings include the following:</p> <p>Per medical record review Resident #1 was admitted on 7/20/15 with diagnosis to include Schizoaffective Disorder, Anxiety, Diabetes, Obesity, Chronic Obstructive Pulmonary Disease, Bilateral Cataracts, Osteoarthritis and Chronic Pain.</p> <p>Physician orders dated and signed on 7/17/15 prior to admission, identifies Resident #1, "No, may not leave the building on pass". This order is confirmed by Unit Manger on 9/14/15.</p> <p>Per Care Area Assessment (CAA) dated 7/27/15 completed by the Licensed Practical Nurse (LPN) who completed the assessment and signed by the Registered Nurse (RN), Director of Nurses (DNS) on 7/31/15, identifies care planning necessary for Resident #1 due to the following concerns: -Known to leave against medical advice at two (2) other facilities, -Bilateral Cataracts, is to have surgery scheduled, -Receiving Physical Therapy due to general</p>	F 281	<p>F281</p> <ol style="list-style-type: none"> Residents #1 had no negative effects from this alleged deficient practice. Resident has been discharged from facility. Residents who can not leave the building on pass can be affected as a result of this alleged deficient practice. Policy and Procedure has been revised for leave of absence/out on pass to include physician order obtained. Staff will be in-serviced on this revision. Audits are ongoing to assure compliance. Results will be reported to the QAPI committee by the DNS for 3 months. Corrective action completed October 5, 2015. <p><i>F281 POL accepted 10/7/15 M.Bertrand RN/PLN</i></p>	
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F 281	<p>Continued From page 7</p> <p>weakness and difficulty walking, -Altered balance/chronic pain requiring the use of a walker, putting Resident #1 at risk for falls, -Resident has poor safety awareness, -Resident receives antipsychotic medication (medication used to treat Schizoaffective Disorder/Bipolar Disease) and has episodes of verbal abuse and aggression towards others.</p> <p>Nurses notes dated at various intervals beginning on 7/20/15 through 9/14/15, evidence that the resident left the facility unattended approximately on 39 separate occasions. The leave of absences varied from fifteen (15) minutes to as long as seven (7) hours in duration and during the day, evening and night hours.</p> <p>Refer to details at F323.</p> <p>References: Per review of the American Medical Association Code of Medical Ethics states "One of the duties in providing reasonable care is fulfilled by a nurse who carries out the orders of the attending physician". [http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion302.page]</p> <p>Per review of the American Nursing Association Code of Ethics states "The primary bond between the practices of medicine and nursing is mutual ethical concern for patients. One of the duties in providing reasonable care is fulfilled by the nurse who carries out the orders of the attending physician". [American Nursing Association Code of Ethics Issued June 1983 and updated June 1994. http://www.nursingworld.org]</p>	F 281		

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F 281	Continued From page 8 Lippincott Manual of Nursing Practice (9th Edition) Wolters Kluwer Health/Lippincott Williams and Wilkins Page #17.	F 281		
F 285 SS=D	<p>483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR</p> <p>A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.</p> <p>A nursing facility must not admit, on or after January 1, 1989, any new residents with:</p> <p>(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p>	F 285	<p>F285</p> <ol style="list-style-type: none"> Residents #1 had no negative effects from this alleged deficient practice. Resident has been discharged from facility. All residents who require a PASSAR can be affected as a result of this deficient practice. PASSARs will be completed and reviewed for accuracy on all new admissions. Audits are ongoing to assure compliance. Results will be reported to the QAPI committee by the Administrator or designee for 3 months Corrective action completed October 5, 2015. <p>Addendum: Admission Coordinator will be responsible for the completion and accuracy of all new admissions related to PASRR.</p>	

F285 POC accepted with addendum 10/7/15
M.Bertrand R.N./PME

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F 285	Continued From page 9 For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview the facility failed to have the State mental health authority determine and ensure that an individual with mental illness receives the care and services needed in the most appropriate setting. For 1 of 25 Pre-Admission Screening and Resident Review (PASRR) forms examined, Resident #1 had a PASRR screening completed, documenting inaccurate information. Therefore, the Mental Health authority was not notified prior to Resident #1 being admitted to the nursing facility. The findings include the following: Per medical record review Resident #1 was admitted on 7/20/15 with diagnosis to include Schizoaffective Disorder, Anxiety, Diabetes, Obesity, Chronic Obstructive Pulmonary Disease, Osteoarthritis and Chronic Pain. Per medical record review PASRR screen dated 7/22/15, incorrectly identifies in Part B-Mental Illness, that Resident #1 has no psychiatric disorders. Per medical record review, the response to the screening completed by the Social Service (SS) employee on 7/22/15 for question #1 was, "None of the Above".	F 285			

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F 285	Continued From page 10 Therefore, the State Mental Health Authority was not notified of the need to evaluate Resident #1 for appropriate admission to the nursing home. SS employee confirmed, that the Department of Mental Health was not notified of the need for further evaluation at the time Resident #1 was admitted or later when decided, that Resident #1's stay exceeded 30 days in the Nursing Facility.	F 285		
F 323 SS=J	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 medical record review and confirmed by staff interview, the facility failed to assure that 1 of 69 residents residing in the facility, receives adequate supervision by facility staff to prevent and/or avoid accidents. For Resident #1 the findings include the following: Per medical record review Resident #1 was admitted on 7/20/15 with diagnoses to include Schizoaffective Disorder, Anxiety, Diabetes, Obesity, Chronic Obstructive Pulmonary Disease, Bilateral Cataracts, Osteoarthritis and Chronic Pain. Physician orders dated and signed on 7/17/15 prior to admission, states, regarding Resident #1, "No, may not leave the building on	F 323	F323 1. Resident # 1 had no negative effects as a result of this alleged deficient practice. Resident has been discharged from this facility. 2. All residents who leave the grounds unsupervised have a potential to be affected by this alleged deficient practice. 3. Staff will be re-educated on the policy and procedure of reporting all alleged elopements immediately and accordance with state law. 4. Audits are ongoing to to assure compliance. Results will be reported to the QAPI committee by the DNS for 3 months. 5. Corrective action completed October 5, 2015. <i>F323 POC accepted 10/7/15 mBertrandR/pmc</i>	

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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 C 09/16/2015
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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 323	<p>Continued From page 11</p> <p>pass". This order is confirmed by Unit Manger on 9/14/15.</p> <p>Per Care Area Assessment (CAA) dated 7/27/15 completed by the Licensed Practical Nurse (LPN) who completed the assessment and signed by the Registered Nurse (RN), Director of Nurses (DNS) on 7/31/15, identifies care planning necessary for Resident #1 due to the following concerns:</p> <ul style="list-style-type: none"> -Known to leave against medical advice at two (2) other facilities, -Bilateral Cataracts, is to have surgery scheduled, -Receiving Physical Therapy due to general weakness and difficulty walking, -Altered balance/chronic pain requiring the use of a walker, putting Resident #1 at risk for falls, -Resident has poor safety awareness, -Resident receives antipsychotic medication (medication used to treat Schizoaffective Disorder/Bipolar Disease) and has episodes of verbal abuse and aggression towards others. <p>Per medical record review, nurses notes dated at various intervals beginning on 7/20/15 through 9/14/15, evidence that the resident left the facility unattended on approximately 39 separate occasions. The leave of absences varied from fifteen (15) minutes to as long as seven (7) hours in duration and during the day, evening and night hours.</p> <p>7/20 through 7/24/15: Resident #1 left the facility without supervision on 5 separate occasions. The resident was seen ambulating with a walker down Crescent Boulevard, heading downtown. Neighbors called the facility to alert the missing resident.</p>	F 323		
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DEPARTMENT OF HEALTH AND HUMAN 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 323	<p>Continued From page 12</p> <p>7/28 through 8/5/15: Resident #1 left the facility without supervision on 7 separate occasions. On 2 occasions the resident appeared in the Emergency Department (ED) for complaints of chest and left arm pain. ED treated and released the resident back to the nursing facility with instructions. Nurses documentation evidences that the resident was out of the facility unattended for durations lasting up to 7 hours.</p> <p>8/6 through 8/13/15: Resident #1 left the facility without supervision on 4 separate occasions. On one of the 4 occasions, the resident appeared at the rescue squad building partially clothed, in a T-Shirt and adult pull-ups.</p> <p>8/14 through 8/22/15: Resident #1 left the facility without supervision on 5 separate occasions. The resident appeared in the ED inappropriately dressed. Nurses documentation evidences that the resident was out of the facility unattended for durations lasting up to 5 hours.</p> <p>8/23 through 8/31/15: Resident #1 left the facility without supervision on 8 separate occasions. The two following episodes documented in the nurses notes, evidence that lack of supervision by facility staff, that placed Resident #1 in situations of severe danger. On 8/28/15 at 5:45 AM the facility was notified by the attendant of a local Gas Station/Minimart, (at the bottom of the hill) that Resident #1 has been directing traffic on Route #7, a major highway. S/he is removing his/her clothing in the Minimart. The establishment would like the resident picked up. Nursing home staff informed Minimart staff they could not meet their request to provide the resident with transportation back to the nursing facility. On 8/28/15 at 2 PM, Resident #1 was</p>	F 323		

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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 _____	(X3) DATE SURVEY COMPLETED C 09/16/2015
NAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS			STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD 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 323	<p>Continued From page 13</p> <p>walking in the circle/driveway in front of the facility, s/he became tired and just stopped. Oncoming vehicles were redirected and the resident was moved by facility staff to the grass where s/he rested.</p> <p>9/1 through 9/14/15: Resident #1 left the facility without supervision on 9 separate occasions. The following episode, documented in the nurses notes, evidence that lack of supervision by facility staff, that placed Resident #1 in situation of severe danger. On 9/1/15 the facility received a call reporting that Resident #1 was seen walking on the yellow line on South Street. Resident was returned to the facility by the rescue squad.</p> <p>Per observation on 9/14/15 the State Surveyor identified that Resident #1 did not have a wander-guard bracelet on his/her person or attached to the walker, therefore the security alert was not in place. Interdisciplinary Care Plan (ICP), dated 8/5/15 identifies that Resident #1 has a history of leaving facilities Against Medical Advice and leaving the facility and grounds without informing staff. Interdisciplinary Care Plan identifies that the resident is at risk for elopement and to have wander-guard bracelet on walker as he allows to alert staff that the resident is leaving the building. On 8/28/15 an initiative on the ICP evidences that Resident #1 has been known to remove clothing and attempt to direct traffic downtown and signed by the Director of Nurses (DNS).</p> <p>On 9/14/15 at approximately 4 PM Surveyor informed the DNS that a plan needed to be put in place to ensure the safety of Resident #1 while s/he is in the facility or out of the premises. A plan was developed and accepted by the</p>	F 323		

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F 323	<p>Continued From page 14 surveyor.</p> <p>9/14/15 Resident #1 left the facility unsupervised at 9:45 PM. Administrator, DNS, United Counseling Service and Bennington Police Department notified. The resident returned around 10:15 PM.</p> <p>Nurses notes identify the following:</p> <ul style="list-style-type: none"> - Concerned citizens have returned the resident to the facility. - Facility staff silence alarm while resident exited the building. - Facility staff do not consistently identify when the resident leaves or returns. - On several occasions resident called the facility, taxi, EMS or Police to be returned to the facility. - Nurses Notes evidence that facility staff will not pick up resident when he or a local establishments requests transportation back to the nursing facility. <p>Per interview with the DNS and the Nursing Home Administrator confirmation was made that the resident has left the facility on 39 documented episodes and at various times of the day, evening and night as noted in the nurses notes. All of the occurrences were without supervision therefore placing the resident in severe danger.</p>	F 323		
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