

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

August 25, 2016

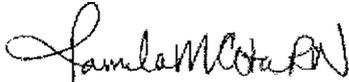
Ms. Wendy Beatty, Administrator
Crescent Manor Care Ctrs
312 Crescent Blvd
Bennington, VT 05201-0170

Dear Ms. Beatty:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 3, 2016**. 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: 08/11/2016
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 08/03/2016
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	F 000			
F 280 SS=D	<p>An unannounced onsite extended survey was conducted by the Division of Licensing and Protection on 8/2 through 8/3/16. The extended survey was conducted as a result of the Immediate Jeopardy and substandard quality of care identified during an investigation completed on 7/26/16. The findings of the extended survey are as follows:</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to 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 observation, record review and confirmed by staff interview the facility failed to</p>	F 280	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.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *W. Beatty* TITLE NHA (X6) DATE 08.22.16

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 280	<p>Continued From page 1</p> <p>review and revise the comprehensive care plan for 1 of 2 sampled residents (Resident #1). The findings include the following:</p> <p>1. Per medical record review, Resident #1 was admitted on 10/30/15 with diagnoses to include Altered Mental Status, Huntington's Disease, Major Depressive Disorder and Type 2 Diabetes.</p> <p>Per nurses notes dated 5/22/16 at 5 PM the Resident #1 ambulated into the woods. Staff were unable redirect the resident back into the facility. The police were notified, who were able to redirect the resident back towards the facility when s/he voiced to the officer that s/he was suicidal. Emergency Medical Service was notified and the resident was transferred to the hospital for evaluation and admission. The resident returned to the facility on 5/23/16.</p> <p>Per care plan review, a care plan was developed dated 5/23/16 for suicidal thoughts. Plan was to monitor whereabouts and activities every 15 minutes, monitor and document suicidal ideation and Emergency Room evaluation.</p> <p>Per review of the nurses notes on 8/2/16 and 8/3/16, there is no evidence that demonstrates that the resident has been monitored for suicidal ideation. 15 Minute Safety Check sheets identify monitoring for Elopement/Fall risk. Behavior sheets do not monitor for suicidal ideations.</p> <p>Per interview with the Huntington Unit Coordinator, confirmation is made that the care plan has not been updated since the 5/22/16 incident as it relates to suicidal ideations.</p> <p>2. In addition, per review of nurses notes for</p>	F-280		

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F 280	<p>Continued From page 2</p> <p>Resident #1, there are various notations through out the month of May, June and July that identify that the resident uses various modes of transportation (wheelchair/rolling walker/independent ambulation) throughout the day/evening/night. On 6/22/16 the resident left the building two (2) times during the night shift. S/He was escorted back into the building by staff.</p> <p>Per observation on 8/2/16 and 8/3/16 Resident #1 was observed ambulating independently (briskly), with a rolling walker to and from his/her room, to the dining room and various other locations in the facility. Per care plan review, Resident #1 is identified as an elopement risk with impaired safety awareness. Interventions to manage elopement include, but not limited to every 15 minute checks, wanderguard bracelet attached to wheelchair and check placement every shift and function daily.</p> <p>Per observation on 8/2/16 in the presence of the Unit Manager, the secure care for Resident #1 was located on the right arm rest of his/her wheelchair located outside the resident's room. The resident was found in the Rehab Department with a Licensed Nurses Aide (LNA). The LNA confirmed that the resident does not have a wanderguard on his/her person. The resident's walker is present and the LNA believes that the bracelet is on the resident's wheelchair.</p> <p>Per interview on 8/2/16 at 2 PM with the Huntington Unit Coordinator, confirmation is made that the care plan does need updating in relation to the wanderguard security bracelet. The resident uses a walker and/or a wheelchair for independent mobility at his/her discretion. The Coordinator also confirms that the staff have</p>	F 280	<p>F280</p> <p>Resident #1 care plan was updated to reflect placement of the wander guard and monitoring for suicidal ideation.</p> <p>All residents who reside in the facility and utilize wander guards or have suicidal ideations are at risk.</p> <p>Staff have been educated on safety checks, interventions and revision of care plans.</p> <p>Audits of wander guard placement and residents being monitored for suicidal ideation will take place weekly x 4 then monthly x 4.</p> <p>Date of Correction: 08/23/2014</p> <p>Responsible: DNS, nurse managers, social services.</p> <p><i>F280 POC accepted 8/24/16 mbertrand RN/pml</i></p>		

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F 280	Continued From page 3 not checked placement every shift nor have they checked the function of the security device since the plan was initiated.	F 280			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by staff interview the facility failed to implement the plan of care for 1 of 2 sampled residents (Resident #1). The findings include the following: Per medical record review, staff failed to implement the care plan for Resident #1 regarding monitoring for suicidal ideation and regarding a wanderguard system. Per care plan review, a problem was developed dated 5/23/16 for suicidal thoughts. Plan was to monitor whereabouts and activities every 15 minutes, monitor and document suicidal ideation and Emergency Room evaluation. Per review of the nurses notes on 8/2/16, there is no evidence that demonstrates that the resident has been monitored for suicidal ideation. 15 Minute Safety Check sheets identify monitoring for Elopement/Fall risk. Behavior sheets do not monitor for suicidal ideations. Per interview with the Huntington Unit Coordinator confirmation is made that there is no documentation related to	F 282	F282 Resident #1 care plan was updated to reflect placement of the wander guard and monitoring for suicidal ideation. All residents who reside in the facility and utilize wander guards or have suicidal ideations are at risk. Staff have been educated on safety checks, interventions and revision of care plans. Audits of wander guard placement and residents being monitored for suicidal ideation will take place weekly x 4 then monthly x 4. Date of Correction: 08/23/2014 Responsible: DNS, nurse managers, social services.		

F282 POC accepted 8/24/16 mBertrand PN/PMU

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F 282	<p>Continued From page 4</p> <p>Resident #1's voiced suicidal ideations since his/her return from the hospital on 5/23/16.</p> <p>Per review of nurses notes there are various notations through out the month of May, June and July 2016 identifying that the resident uses various modes of transportation (wheelchair/rolling waiker/independent ambulation) throughout the day/evening/night. Documentation evidences that on 5/22/16 the resident was located in the parking lot/back woods of the facility and was later transferred to the hospital. On 6/22/16 the resident left the building two (2) times during the night shift. S/He was escorted back into the building by staff. Per observation on 8/2 and 8/3/16, Resident #1 was observed ambulating independently (briskly) with a rolling walker to and from his/her room, to the dining room and various other locations in the facility.</p> <p>Per care plan review, Resident #1 is identified as an elopement risk with impaired safety awareness. Interventions to manage elopement include, but not limited to every 15 minute checks, wanderguard bracelet attached to wheelchair and check placement every shift and function daily. Per observation on 8/2/16 in the presence of the Unit Manager, the secure care for Resident #1 was located on the right arm rest of the resident's wheelchair located outside his/her room. The resident was found in the Rehab. Department with a Licensed Nurses Aide (LNA). The LNA confirmed that the resident does not have a wanderguard on his/her person, h/his walker is present and the LNA believes the bracelet is on the resident's wheelchair.</p> <p>Per interview on 8/2/16 at 2 PM with the</p>	F 282			

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F 282	Continued From page 5 Huntington Unit Coordinator confirmation is made that the resident uses a walker and/or a wheelchair for independent mobility at his/her discretion. The Coordinator also confirms that the staff have not checked placement every shift nor have they checked the function of the security device since the plan was initiated.	F 282			
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure that 1 of 2 residents (Resident #1) who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. Per medical record review, Resident #1 was admitted on 10/30/15 with diagnosis to include Altered Mental Status, Huntington's Disease, Major Depressive Disorder and Type 2 Diabetes. Per nurses notes dated 5/22/16, Resident #1 was transported to the hospital due to voiced suicidal ideations. On 5/23/16, s/he returned to the facility after evaluation and treatment. On 6/22/16 the resident left the building two (2) times during the night shift. S/He was escorted back into the building by staff.	F 319	F319 Resident #1 had no negative affect as a result of this alleged deficient practice. Social Services has updated progress notes regarding resident #1 and suicidal ideation. All residents who reside in the facility with suicidal ideations have the potential to be affected. Social services have been educated on the importance of documenting interactions, observations or lack of response from residents who reside in the building. Audits are ongoing to assure compliance. Results will be reported to the QAPI committee by social services for 3 months. Date of correction: 8/23/2016 Responsible: Social Services <i>Addendum above per phone call with Wendy Beatty, Administrator, on 8/24/16</i> <i>F319 POC accepted with addendum 8/24/16 M. Bertrand R#1 JMC</i>		

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F 319	Continued From page 6 Per review of the progress notes dated 5/22/16 through 7/5/16, there is a notation from Social Services (SS) on 5/23/16 identifying assistance with return to the facility after hospitalization. A second notation dated 6/1/16 identifies that SS attempted to communicate with the resident who refused the visit, and a 3rd notation on 6/23/16 documenting a phone conference with family. Per review of the Interdisciplinary Care Plan for Resident #1, SS is included for problems related to isolation, behaviors identified as anxiety/aggressiveness, adjustment difficulties, verbally abusive, elopement, impaired safety awareness, cognitive deficit, communication deficit, delusions and poor decision making skills. Per interview with SS, the resident is often resistive to most communication. The resident frequently will dismiss staff if s/he doesn't want any further interaction. SS does not document any of the interactions, observations or lack of response from the resident. Therefore, confirmation can not be made that SS has assisted Resident #1 with adjustment difficulties or any of the care planned problems s/he is responsible for.	F 319			
F 329 SS=D	483.25(l) 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	F 329			

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F 329	<p>Continued From page 7</p> <p>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 confirmed by staff interview, the facility failed to ensure that 1 of 2 applicable residents (Resident #1), has a drug regimen that is free from unnecessary drugs. The findings include the following:</p> <p>Per medical record review, Physician orders signed and dated on 7/29/16 for Resident #1, identify the following medication orders:</p> <p>-Risperidone 2 mg (milligrams) Orally Disintegrating Tablets (ODT) one tablet by mouth (po) twice daily. If refuses the ODT then attempt syrup/liquid. Offer through out the day if refused initially and continues to refuse give 4 mg po at bedtime (HS) for diagnosis of Huntington's Chorea. (This is an antipsychotic</p>	F 329	<p>F329</p> <p>Resident #1 had no negative effects as a result of this alleged deficient practice. Injectable medications have been discontinued for resident #1 since they were never administered.</p> <p>All residents with orders for PRN antipsychotic IM have the potential to be affected.</p> <p>Staff have been educated on the proper usage of antipsychotic IM medications and the interventions necessary prior to usage.</p> <p>Chart audits will take place weekly X4 and then monthly X4 with results reported through the QAPI process.</p> <p>Date of correction: 8/23/2016</p> <p>Responsible: Nurse Managers, DNS</p> <p><i>F329 POC accepted 8/24/16 mbertrand/pme</i></p>		

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F 329	<p>Continued From page 8</p> <p>medication used in the treatment of Huntington's Disease to manage psychiatric disorders that accompany the disease.)</p> <p>-Ativan emergency treatment plan: if patient is aggressive, violent or threatens others: Ativan 1 mg Intramuscularly (IM) one (1) time as needed (prn). (Ativan an antianxiety/sedative medication used to manage suicide ideation, impaired memory and judgement.)</p> <p>Further care need for Emergency Department Assessment and management to be determined after administration for diagnosis of aggression/violence.</p> <p>-Haldol emergency treatment plan: If patient aggressive/violent or threatens others Haldol 2 mg IM prn one (1) time. Further care need for Emergency Department Assessment and management to be determined after administration for diagnosis of aggression/violence.</p> <p>(This is an antipsychotic medication used in the treatment of Huntington's Disease to manage psychiatric disorders that accompany the disease.)</p> <p>-Ativan 1 mg tablet po every 6 hours as needed (prn) agitation or aggression.</p> <p>-OK to put liquid Risperidone into beverage for diagnosis of behaviors.</p> <p>The orders do not identify nonpharmalogical alternatives to the administration of the injectable medications, nor are there parameters directing staff as to order in which the medications should be administered. There is no direction to the staff as to the amount of time between administrations of the various medications.</p> <p>Per review of the Medication Administration Record (MAR) for the month of July for</p>	F 329		
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F 329	Continued From page 9 Resident #1, documentation evidences that s/he has received Risperidone 2 mg ODT twenty-four (24) out of sixty-two (62) opportunities. PRN antianxiety and antipsychotic injectable medications have not been administered in July or August to date. Per review of the physician orders with the Unit Coordinator, confirmation is made that there is no direction indicating nonpharmaloogical alternatives to the administration of the injectable medications nor are there parameters directing staff as to order in which the medications soul be administered. There is no direction to the staff as to the amount of time between administration of various medications.	F 329		
F 517 SS=C	483.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by staff interview, the facility failed to ensure that their written disaster plans have current up to date information. The findings include the following: The facility has 6 manuals each located in the Administrator's Office, North and South Nursing Units and Dietary, Rehabilitation and Activity Departments.	F 517		

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F 517	<p>Continued From page 10</p> <p>1. Per review of the Emergency and Disaster Preparedness manuals, the Chain of Command for notification has contact information that is inaccurate. The call list, identifies the previous Director of Nurses and the previous Manager on the Dementia Unit. The State Emergency Contact list also had an inaccurate telephone number for the Department of Aging and Independent Living (DAIL).</p> <p>Per interview with the Administrator and the Director of Nurses, confirmation was made that the Chain of Command information is inaccurate and the telephone number for DAIL is incorrect as well.</p> <p>2. Per review of the Emergency and Disaster Preparedness manuals, the electric outage/generator failure plan, directs staff to "Replace O2 (oxygen) concentrators with portable O2 tank to ensure oxygen flow is maintained. PO2 (partial pressure of oxygen—the amount of oxygen gas dissolved in the blood), must be greater or equal to 90%".</p> <p>Per interview with the Director of Nurses confirmation was made that there is no clear direction for staff with the management of residents placed on portable oxygen.</p> <p>3. Per review of the Emergency and Disaster Preparedness manuals plan for floods, identifies that "Crescent Manor could possibly experience an internal flood if a sprinkler head releases or a water pipe breaks".</p> <p>Per interview with the Director of Nurses confirmation is made that there is no clear direction for staff to manage an internal flood.</p>	F 517	<p>F517</p> <p>All emergency/disaster plans have been updated to reflect current information.</p> <p>No residents were affected by this alleged deficient practice.</p> <p>Emergency/Disaster plans will be reviewed at safety committee meetings and updated as necessary.</p> <p>Audits will take place monthly x 4. Results will be reported to QAPI committee by Director of Environmental Services.</p> <p>Date of correction: 8/23/2016</p> <p>Responsible: Director of Environmental Services</p> <p><i>F517 POC accepted 8/24/16 mBertrand RN / PINE</i></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 C 08/03/2016
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