

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

December 22, 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 **November 18, 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,



Suzanne Leavitt, RN, MS
Assistant Division Director
Director State Survey Agency



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

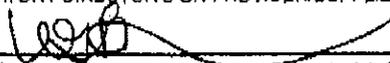
PRINTED: 12/07/2015
FORM APPROVED
OMB NO. 0938-0391

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 11/18/2015
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	F 000		
F 241 SS=E	<p>An unannounced onsite recertification survey and investigation of 5 complaints and self-reports were conducted by the Division of Licensing and Protection on 11/16/15 - 11/18/15. The following are regulatory deficiencies cited as the result.</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 and staff interview, the facility failed to 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 for applicable residents (Residents # 18, 52, 72, 44, 51, 38, 25, 8, 42, 37, 67, 12, 61, 82, 41, 28, 39, 80, 24, 30). Findings include:</p> <p>1. Per observation on 11/16/15 at 4:09 PM, there was personal health information (PHI) hanging in the shared bathrooms of residents #18, 52, 72, 44, 51, 38, 25, 8, 42, 37, 67, 12, 61, 82, 41, 28, 39, and 80 on the North Unit. The PHI included written information regarding continence status and behaviors. The PHI was in clear view of any staff, residents or visitors that entered the bathrooms. Interviews with Licensed Nursing Assistants (LNAs) and unit nurses confirmed that residents often used the bathrooms unattended by staff. The Unit Manager confirmed the</p>	F 241	<p>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.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE



NHA

12.17.15

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 241	Continued From page 1 observations on 11/16/15 at 4:45 PM and agreed that the PHI was visible to anyone entering the bathrooms. 2. Per observation on 11/17/15 in the afternoon for a period of greater than one hour, Resident # 24 was in the bed wearing an adult diaper and short tee shirt in full view from the hallway. There were no sheets available nor was the door or privacy curtain pulled. At that time the nurse surveyor asked the resident if a sheet or blanket was wanted and the resident responded "yes!". Staff then realized no sheets were available and retrieved a sheet from the linen cart and covered the resident. 3. Per observation on 11/17/15 at 3:00 PM, an LNA was pulling Resident #30 backward in a chair down the length of the hall from his/her room to the designated Huntington's room, the Crescent Club. The unit manager (UM) also witnessed at this time that the action was un dignified and confirmed that it was an unacceptable practice to have a resident pulled backward in a chair down the hall.	F 241	F241 All PHI was removed from bathrooms. Bed covers have been brought to resident rooms. All residents are identified as having the potential to be affected. Education has been provided to nursing to utilize the care tracker system for PHI information. Staff have been educated to provide linens in rooms even if resident refuses. Staff have also been educated on the need to move residents in a forward direction unless care planned otherwise. An audit tool has been developed to ensure there is no patient info in bathrooms and linens are in rooms. Audits will be completed by the DNS weekly x 4 and monthly x 4. Results will be reported to QAPI. Date of compliance: December 17 2015 Responsible: DNS	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		

F241 POC accepted 12/22/15 SEMINOW RN/PMC

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F 279	<p>Continued From page 2</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that a comprehensive plan of care was developed for Resident #6 who was receiving a Psychotropic medication. Findings include:</p> <p>Per record review Resident #6 was receiving the Antipsychotic medication Seroquel 12.5 mg PO (by mouth) QHS (every bedtime). In a review of the comprehensive plan of care there is no care plan section for Psychotropic Medications nor any section which addresses the use of psychotropic medications, measurable goals and identified needs such as side effects, adverse effects, gradual dose reductions, and monitoring parameters. In an interview on 11/17/15 at 3:30 PM the Unit Manager confirmed that there was no care plan for psychotropic medications.</p>	F 279	<p>F279</p> <p>Resident #6 care plan was updated to reflect usage of psychotropic medication.</p> <p>Residents who receive psychotropic medications have a potential to be affected.</p> <p>Education will be provided for the center staff on utilizing immediate needs care plans for psychotropic medications.</p> <p>Care plan audits will take place weekly x 4 and then monthly x4 with results reported through the QAPI process.</p> <p>Date of compliance: December 17 2015</p> <p>Responsible: DNS and Nurse Managers</p>
F 280 SS=D	<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</p>	F 280	<p><i>F279 POC accepted 12/18/15 SEMINOW PN</i></p>

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F 280	<p>Continued From page 3</p> <p>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 interviews the facility failed to revise care plans regarding care and services for 2 of 25 residents in the sample (Resident # 24 & #53) Findings include:</p> <p>1. Resident #24's care plan was not revised to show clear interventions to reflect broken/missing teeth and mouth pain. Per initial observations on 11/16/15 and subsequent interview on 11/18/15 at 8:15 AM the resident stated, "I am missing two teeth, I lost my false one when I fell" and acknowledged "teeth hurt sometimes". Per record review, the annual MDS (Minimum Data Set) dated March 2015 as well as the quarterly reviews dated 06/15/15 and 09/11/15, section L, does not reflect that the resident has missing teeth nor any mouth or facial pain, discomfort or</p>	F 280	<p>F280</p> <p>Resident #24 care plan was updated to reflect broken/missing teeth. Resident #53 is no longer on fluid restrictions.</p> <p>Residents who reside at the center are and have broken/missing teeth or fluid restrictions are identified as having the potential to be affected.</p> <p>Education will be provided for the center staff on reviewing and revising resident care plans specifically for broken/missing teeth and fluid restrictions.</p> <p>Care plan audits will take place weekly x 4 and then monthly x4 with results reported through the QAPI process.</p> <p>Date of compliance: December 17th 2015</p> <p>Responsible: DNS and Nurse Managers</p> <p><i>FASO POC accepted 12/22/15 Simmons RN/pml</i></p>	

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F 280	<p>Continued From page 4 difficulty with chewing.</p> <p>The care plan and ADLs (Activity of Daily Living) shows that the "resident has own teeth". There is no mention of the missing/chipped teeth nor does it address mouth pain. A care plan meeting note of 04/16/15 presents "(Dentist) called to evaluate broken front tooth as noted by staff notes of extreme pain and requesting stronger meds regarding a fall on 3/20/15." On 4/21/15 a Dental consult notes states #8 [tooth] was avulsed in a fall, was seen in the ER stitches to lip and after care I was called to see if it was healing. The site were #8 was appears WNL [within normal limits]. On 05/15/15 the dental note states the patient has an ulcerated lip from #9 [tooth] having a chipped sharp medial edge the patient isn't nearly still enough to restore this but I was able to smooth the sharp edge. Per interview on 11/18/15 at 9:07 AM the DNS confirmed that the care plan was not revised to reflect the broken/missing teeth and mouth pain since the incident on 3/20/15.</p> <p>2. The facility failed to revise the care plan to show concise interventions related to fluid restrictions for Resident #53. According to the initial care plan dated 10/28/15, for fluid restriction related to end stage liver failure, ascites and paracentesis [fluid removal], directs staff to restrict fluid to greater than 1000 ml. and to monitor I&O [intake and output]. Per review of a physician progress note and a dietician assessment note dated 11/08/15 & 11/12/15 respectively, fluids were to be restricted to 1500 cc a day, with limit of 250 cc by nursing (60cc per med pass) and a limit of 1250 cc from all dietary sources. During interview on 11/18/15 at 1:30 PM</p>	F 280			

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F 280	Continued From page 5 a staff nurse stated "I give 120 cc with my two med passes which is 240cc for my shift". The dietician who was present at that time, stated that that was incorrect and pointed to the medication administration limits as noted on the diet assessment dated 11/12/15. The dietician acknowledged that the care plan as written "restrict fluids to greater than 1000ml" doesn't make sense. S/he confirmed that the care plan was not revised to show current fluid restriction parameters.	F 280	
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to adhere to professional standards for 4 of 25 applicable residents regarding safe medication administration practices, documentation in the Narcotic book, physician orders, and implementation of physician orders. (Residents #15, 30, 36 & 76) Findings include: 1. Per record review, Resident #36 was sent to the Emergency Department (ED) for possible improper medication administration, without notifying the physician at that time. Resident #36 required hospitalization, oxygen and 2 treatments of Narcan [for narcotic overdose] on 11/04/15.	F 281	

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F 281	<p>Continued From page 6</p> <p>Per review of the 11/04/15 morning nursing progress note, the Resident was "observed shaking, acting not [him/herself] and the eyes rolled back". In addition, the hospital notes of 11/04/15 shows the emergency medical service (EMS) stating that it was reported [by nursing home staff] that the resident was "unresponsive for about 30 minutes". The hospital report shows that the resident's presentation "was consistent with narcotic ingestions" and the toxicology report was positive for oxycodone and other opiates. Staff later in the evening sent a fax to the physician to review and verify the medication list, in which the physician replied "did not know pt [patient] was sent to ED..."</p> <p>In addition, review of the night nurse's statement on 11/05/15 showed that the nurse was having problems with the electronic medication administration record (eMAR), had pre-poured medications and then later in the shift signed off that the medications were given. The statement notes "at 5 AM I could not sign on....poured meds for the six residents who get 5 AM meds...the cups were clearly labeled with resident's names...when the day nurse came in...I signed for all the meds given, at that time".</p> <p>Per interview on 11/17/15 at 2:54 PM the SDC [Staff Development Coordinator] stated that the medications are not to be pre-poured for all the residents but given individually and documented at that time. Per interview DNS on 1:22 PM on 11/17/15 stated the night nurse did not have total access [to the medication record] via eMAR and acknowledged that there is one resident on that side of the unit who has orders for oxycontin, morphine and ativan. The DNS further that the night nurse denied giving the wrong medication</p>	F 281	<p>F281</p> <p>Resident #36 is back to baseline. Narcotics destroyed and physician orders updated.</p> <p>Residents with narcotic and positioning devices have a potential to be affected.</p> <p>Restraint/enabler policy has been revised and a worksheet added. Monthly physician order sheets no longer have end dates. Education provided to nurses regarding signing narcotic logs timely. Weekly reminders to destroy any unnecessary narcotics and nurses have been re-educated on EMAR policies.</p> <p>An audit tool has been developed. Audits will take place weekly x4 and then monthly x4 with results reported through the QAPI process.</p> <p>Date of correction: December 17 2015</p> <p>Responsible: DNS and Nurse Managers</p> <p><i>FBI POC accepted 12/22/15 Semman RN/AM</i></p>	

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F 281	<p>Continued From page 7</p> <p>but had resigned after this incident. The facility's investigation was inconclusive, however, the DNS stated "the thought was that [Resident #36] had possibly received the other resident's medication."</p> <p>2. During investigation of the emergency medical treatment required for Resident #36 on 11/4/15, it was found that staff are "pre-signing" the Narcotic Book and that discontinued medications are not being disposed of in a timely manner. Per review of the Narcotic Book shows Resident #36 had one dose of Tylenol w/ Codeine on 10/28/15 and was discontinued on 11/05/15, however the medication was still in the facility, 3 weeks later. Documentation in the Narcotic book shows evidence of "pre-signatures" and/or missing co-signatures for the month of November on the west and east sides of the unit. The special care unit (SCU), North 1 & 2, had missing and/or "pre-signed" signatures. Per interview at that time, the West second shift staff nurse stated "we sign ahead of time so we don't forget to sign off and we tend to get rid of the narcotics within a week", while the SCU nurse stated "I'm new so I am not sure the protocol for destroying meds but we all sign our names before the other nurse counts with us, so we don't forget".</p> <p>Per interview on 11/17/15 at 2:54 PM the SDC [Staff Development Coordinator] stated that although the policy states to dispose of narcotics in a timely manner and that the expectation is within a week, that did not happen. The SDC confirmed the above findings that staff failed to adhere to professional standards. Also see F-333.</p> <p>3. Per review of medical records, Residents #15,</p>	F 281		

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F 281	<p>Continued From page 8</p> <p>30 and 76 had no physician orders in place for November 2015. The physician orders in the medical records, signed by the physician and dated 9/27/15, state, "All orders are valid from Oct 1st to Oct 31st unless otherwise indicated." Per interview with the Licensed Practical Nurse (LPN) coordinator for the Huntington's Unit, the process for monthly orders is to copy the orders sent from the pharmacy and then send them to the physicians for review and signature. Confirmation from the Registered Nurse on 11/18/15 at 1:40 PM that the physician had not signed the current orders for November and that the orders in the chart are dated to be valid only until October 31.</p> <p>4. Resident #15 has a diagnosis of Huntington's Chorea and per record review on 11/17/15, s/he has a physician order dated 6/11/14 for trunk support while in broda chair, release every 2 hours. Per review of the safety checks surrounding the release of the support, it is to be done every 2 hours and there is no evidence that it has been consistently released for the past three days. Confirmed by the LPN on 11/17/15 at 4:18 PM, that the documentation is incomplete and there is no evidence that the support has been released per the physician orders. Per observation on 11/18/15 at 7:53 AM, Resident #15 was observed being taken to the dining room and chest strap and pelvic support were in place. Resident was fed breakfast and at 9:19 AM was brought to the unit and was placed in the sitting room. At 9:32 AM s/he was brought into the Crescent Club (an area specified for the Huntington's residents). The chest strap was removed at 10:00 AM for less than 1 minute to reposition the resident. The pelvic support strap was not released and per interview with the</p>	F 281			

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F 281	Continued From page 9 Physical Therapist at this time, the straps are loose enough and don't need to be released. S/he confirmed that they keep the resident from getting out of the chair and are used for safety and support because of choreic movements. The resident was then taken to occupational therapy. Per the LNA, the resident spends most of his/her day in the Crescent Club and the supports are not released. Per the Huntington's coordinator, at 10:15 AM, the physician orders were not followed.	F 281		
F 282 SS=E	Reference: Lippincott Manual of Nursing Practice (9th edition) Wolters Kluwer Health/Lippincott Williams and Wilkins 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, staff interview and record review, the facility failed to follow the written care plan for 3 of 25 residents in the sample, Resident #15, #30 and #53. Findings include: 1. Per record review, Resident #30 has a diagnosis of Huntington's Chorea and per staff interviews s/he requires total assist with all Activities of Daily Living. Per observations on 11/18/15 at 7:53 AM the resident was brought to the dining room and there was no evidence of a	F 282	F282 Residents #15, #30 and #53 were not affected by this alleged deficient practice. Residents care planned for fluid restrictions, positioning devices, skin integrity and incontinence care have a potential to be affected. Staff will be in-serviced on following care plans. Residents with skin integrity issues will be visually monitored daily. Audit tool has been developed to verify compliance regarding incontinence, positioning, fluid restrictions and skin integrity. Audits will take place weekly X4 and then monthly X4 Results will be reported to QAPI. Responsible: DNS or designee Date of correction: December 17, 2015	

F282 POC accepted 12/22/15 SEMINOR RA/PMC

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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		
(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 282	<p>Continued From page 10</p> <p>chest strap in place as per care plan dated 7/17/15 that indicates resident is to have chest support when eating to increase positioning. The resident was fed breakfast by the Registered Nurse (RN) and per confirmation at 9:20 AM, the RN that fed the resident breakfast stated that the resident did not have a chest support in place during his/her meals as per care plan.</p> <p>2. Per record review, Resident #30 has a care plan dated 9/16/15 regarding skin integrity to monitor for any bruises/skin tears every shift and initiate any necessary treatment as indicated. Review of the medical record did not provide evidence of the monitoring for skin conditions and per confirmation 11/17/15 at 4:00 PM with the Licensed Practical Nurse (LPN) Huntington's Coordinator, there is no evidence that the staff is monitoring skin conditions every shift according to the care plans.</p> <p>3. Per record review, Resident #15 has a diagnosis of Huntington's Chorea and has a care plan dated 6/25/15 that indicates s/he is to have incontinence care before and after meals, at HS (hour of sleep), every 2-3 hours at night and as needed. Per observation 11/18/15 7:53 AM observed resident being taken to the dining room and then returned to the unit at 9:19 AM when brought to television sitting room on the unit. At 9:32 AM s/he was then brought into the Huntington's club (Crescent Club) and was watching television. At 10:02 AM the resident was then taken to occupational therapy for ROM and positioning. Per the LNA at 10:55 AM, the resident had not been toileted during this time per care plan.</p> <p>4. Facility staff did not follow the care plan</p>	F 282			

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F 282	Continued From page 11 regarding fluid restrictions for Resident #53. Per observation on 11/18/15 at 1:02 PM, a nearly empty two litter bottle of Ginger Ale was noted on the floor as well as a full two litter bottle on the resident's closet shelf. When staff entered the room at that time, at the resident's request, they handed the resident the full two litter bottle from the closet and took the now finished two litter bottle away. According to the initial care plan dated 10/28/15, for fluid restriction related to end stage liver failure, ascites and paracentesis [fluid removal], it directs staff to restrict fluid to "greater than 1000 ml." and to monitor I&O [intake and output]. Per review of a physician note and a dietician note dated 11/08/15 & 11/12/15 respectively, fluids were to be restricted to 1500 cc (cubic centimeters, same as 'ml') a day, with limit of 250 cc by nursing (80cc per med pass) and a limit of 1250 cc from all dietary sources. Review of the I&O shows inconsistencies [a range of fluids from 800cc to greater than 2100cc] as well as missing total amounts during the above time period. The staff nurse stated on 11/18/15 at 1:30 PM "I give 120cc with my two med pass which is 240cc for my shift". The dietician who was present at that time, stated that that was incorrect and pointed to the medication administration limits as noted on the diet assessment. The dietician acknowledged that fluids should be monitored closely and within the current stated parameters and confirmed that the care plan was not followed for the fluid restriction.	F 282			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323			

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F 323	Continued From page 12 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 record review and staff interviews the facility failed to assure that Resident #6 received adequate supervision and assistance to prevent accidents. Findings include: Per record review, a Falls Committee Review report stated that Resident #6 was out of doors on 10/31/15 at 3:50 PM. Resident #6 was accompanied by a Licensed Nursing Assistant (LNA) and became tired and weak. S/he was using a Rollator (a wheeled walker with a seat) and s/he sat down on the seat of his/her walker. Per the note the LNA assisted the resident to be seated and then attempted to push him/her back into the facility seated on the walker. The walker became "stuck" on an uneven portion of the sidewalk and tipped backwards causing the resident to fall landing on the sidewalk. The resident hit his/her head and had a "lump" on the back of his/her head and ice was applied. In an interview, the Unit Manager confirmed on 11/17/15 at 3:45 PM the sequence of events described in the note and that the LNA should not have attempted to transport a resident seated on a Rollator. In an interview on 11/17/15 at 4:15 PM the Director of Nursing Services confirmed that there was no incident report written regarding the incident and no record of remediation of the LNA.	F 323	F323 Teaching has been provided to staff who care for resident #6 that rollators are to be used just for sitting/resting. Residents who utilize rollators have the potential to be affected. Staff will be in-serviced on proper usage of rollators. Visual audits will take place regarding the proper usage of Rollator devices. Results will be reported to QAPI monthly X4. Date of correction: December 17, 2015. Responsible: Nurse Managers <i>F323 PCC accepted 12/22/15 SEMMAR/PPN/PM</i>		

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F 333 SS=G	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to ensure that 1 applicable sampled resident (Resident #36), was free of any significant medication errors. The findings include:</p> <p>Resident #36 was sent to the Emergency Department (ED) on 11/04/15 in which the hospital report shows that the resident's presentation "was consistent with narcotic ingestions" and the toxicology report was positive for oxycodone and "other opiates". The resident needed two doses of Narcan [antidote for opioid overdose].</p> <p>Review on 11/16/15 of the current medications shows no narcotics nor other opioids ordered for this resident. Tylenol #3 [with codeine] was discontinued and last given on 10/28/15. Per review of the night nurse's statement on 11/05/15 showed that the nurse was having problems with the electronic medication administration record (eMAR), had pre-poured medications and then later in the shift signed off that the medications were given. The statement notes "at 5 AM I could not sign on....poured meds for the six residents who get 5 AM meds...the cups were clearly labeled with resident's names...when the day nurse came in...I signed for all the meds given, at that time".</p>	F 333	<p>F333</p> <p>Resident #36 is back to baseline.</p> <p>All residents who receive narcotics have the potential to be affected.</p> <p>Nursing staff have been re-educated on the EMAR system policy and procedures.</p> <p>Audits will take place regarding proper narcotic administration weekly X4 then monthly X4. Results will be reported to QAPI.</p> <p>Responsible: DNS, Nurse Managers</p> <p>Date of compliance December 17, 2015.</p> <p><i>F333 POC accepted 12/22/15 Semmons RW/PML</i></p>	

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F 333	Continued From page 14 Per interview DNS on 1:22 PM on 11/17/15 stated the night nurse did not have total access [to the medication record] via eMAR and acknowledged that there is one resident on that side of the unit who has orders [for opioids] oxycontin, morphine and ativan. The DNS further that the night nurse denied giving the wrong medication but had resigned after this incident. The facility's investigation was inconclusive however, the DNS stated "the thought was that [Resident #36] had possibly received the other resident's medication."	F 333		
F 356 SS=B	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	F 356	F356 No residents were affected by this alleged deficient practice. No residents have the potential to be affected by this alleged deficient practice. Postings will be reflect current data and be maintained for 18 months. Audits will take place weekly X4 then monthly X4. Results will be reported to QAPI. Date of compliance December 17, 2015. Responsible: Staffing coordinator or designee <i>F356 POC accepted 12/22/15 semmon RN/PMC</i>	

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F 356	<p>Continued From page 15 for review at a cost not to exceed the community standard.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to post nurse staffing information with the current date and maintain the posted daily nurse staffing data for a minimum of 18 months. Findings include:</p> <p>Per observation during the initial tour on 11/16/15 at 10:20 AM it was noted that there was no current nurse staffing information posted. The date on the posted nurse staffing information was 11/6/15 and the second posting was dated 11/4/15. Per observation at 10:35 AM on 11/16/15 the facility scheduler was actively posting the nurse staffing information for 11/16/15. Per interview on 11/16/2015 at 10:35 AM the scheduler confirmed that the 11/16/15 nurse staffing information was not posted and that he/she did not keep the nurse staffing data for a period of at least 18 months.</p>	F 356	
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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 of disease and infection.</p>	F 441	

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F 441	<p>Continued From page 16</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <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 on observation and interview the facility failed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection. Findings include:</p>	F 441	<p>F441</p> <p>Toilet rise seat removed from bathroom.</p> <p>All residents who utilize rise seats and receive dressing changes have the potential to be affected by this deficient practice.</p> <p>Bathroom rounds will be conducted by the DNS. Staff will be re-in serviced on removal of trash from rooms with gloves post dressing change.</p> <p>Audits will take place weekly X4 then monthly X4. Results will be reported to QAPI.</p> <p>Responsible DNS and Infection Control</p> <p>Date of Compliance December 17, 2015</p> <p><i>F441 POC accepted 12/12/15 SEMM/DNS/PN/PNA</i></p>	

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F 441	<p>Continued From page 17</p> <p>1. Per observation during the initial tour of the North Wing on 11/16/15 at 10:30 AM it was noted that in the shared bathroom between rooms one and three there was a large amount of dried black/brown, odorous material located on the commode over the toilet. Per observation on 11/17/15 at 9:30 AM it was noted that in the shared bathroom between rooms one and three there continued to be a large amount of dried black/brown, odorous material noted on the commode over the toilet. Per interview on 11/17/15 at 9:43:06 AM the Nurse Manager confirmed that there was fecal matter on the commode in the shared bathroom between rooms one and three. He/she confirmed that the commode was not cleaned after use. He/she confirmed that the residents who use the shared bathroom between one and three are ambulatory.</p> <p>2. Per observation on 11/17/15 at 11:53:33 AM a Licensed Practical Nurse (LPN) had finished a dressing change and was cleaning up her work space. He/she removed the garbage with the dirty dressing materials from the garbage can without gloves. Per interview with the LPN he/she confirmed that he/she was not wearing gloves and that the facility protocol was to wear gloves when touching soiled linen or garbage.</p>	F 441			

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AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475033	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	DATE SURVEY COMPLETE: 11/18/2015
NAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS	STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD BENNINGTON, VT		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 205	<p>483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR</p> <p>Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and interviews of others, as well as record review, the facility failed to provide 1 of 5 residents in the sample, Resident #27, with written information regarding a bed hold policy. Findings include:</p> <p>Per record review, Resident #27 was admitted to the facility from the services of United Counseling Service (UCS) in July of 2015 with an extensive history of schizoaffective disorder and not being able to manage medications on his/her own. The resident also had a history of signing self out of facilities against medical advice and has been homeless on several occasions. He/she was discharged from the facility on 9/15/15 after a meeting with his/her UCS caseworker and others after several disruptive episodes at the facility and the resident felt that s/he needed to have their medications adjusted. Per record documentation, written by the Director of Nurses, Resident #27 was discharged to Southwest Vermont Medical Center (SVMC) with UCS case worker. Per interview with case worker, the resident was not discharged to his/her care and that the facility had made arrangements to transport to the hospital. Per interview with the administrator on 11/17/15 at 11:05 AM, the resident was his/her own responsible party and that it was a verbal agreement that the resident would be discharged and the UCS caseworker took all the notes of the meeting and the facility did not have record of the meeting. The administrator also stated that the bed hold policy is given for residents that are being discharged and it is good for 10 days unless the resident wants to pay privately. Interview with the social service worker at 12:21 PM presented that s/he stated that there was no bed hold letter given to the resident because they were unsure where s/he was going.</p> <p>*This is an "A" level deficiency.</p>		
F 387	<p>483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475033	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 11/18/2015
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NAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS	STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD BENNINGTON, VT
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 387

Continued From Page 1 .

A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the MD did not visit at least every 60 days as per requirements for 1 of 4 residents #76. Findings include:

Record review on 11/18/15 of physician progress notes for Resident #76, the resident was seen 3/1/15, 5/2/15 and not again until 9/8/15. Per interview with the Registered Nurse (RN) Unit Manager at 1:40 PM, there is no evidence to present that the physician and seen the resident and that the resident was on the list to be seen for November, but per RN it did not occur.

*This is an "A" level deficiency.