

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

October 3, 2016

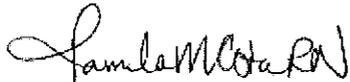
Ms. Wendy Beatty, Administrator
Crescent Manor Care Ctrs
312 Crescent Blvd
Bennington, VT 05201-0170

Dear Ms. Beatty:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 14, 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

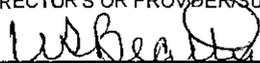
SEP 30 2016

PRINTED: 09/27/2016
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 R-C 09/14/2016
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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
{F 000}	INITIAL COMMENTS	{F 000}		
{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> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (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. (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. (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</p>	{F 441}	<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 NHA	(X6) DATE 09.27.16
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 441}	<p>Continued From page 1 infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection for 3 out of 5 residents regarding nebulizer administration and storage (Resident #1, Resident # 2, Resident # 3). Findings include: Per observation on 9/14/16 at 9:53 AM of the South Unit, a nebulizer mask was noted to be uncovered, on top of a nebulizer machine, on a bedside table in Resident # 1's room. Per interview on 9/14/16 at 9:56 AM with a Registered Nurse (RN), s/he confirmed that the nebulizer mask should have been in a bag and s/he proceeded to throw the mask away. Per observation on 9/14/16 at 11:37 AM of a nebulizer treatment administration for Resident # 2, the RN identified the resident, obtained the nebulizer mask from the resident's bag on the bedside table, proceeded to put the liquid nebulizer medication in the medication chamber, placed the nebulizer mask over the resident's nose and mouth, turned the nebulizer machine on to start the treatment and left the room. The RN did not wear gloves for the nebulizer medication administration. The RN also did not wash his/her hands after the medication administration and/or prior to leaving the resident's room. Per observation on 9/14/16 at 12:15 PM of a nebulizer treatment administration for Resident # 3, the Licensed Practical Nurse (LPN) identified</p>	{F 441}	<p>F441</p> <p>Residents #1,2 and 3 had no negative effects from this alleged deficient practice. Masks were discarded.</p> <p>All residents who reside in the facility and receive nebulizer treatments have the potential to be affected by this alleged deficient practice.</p> <p>Staff have been educated on the policy and procedure for nebulizer treatments and maintenance. Staff have been also been educated on performing proper hand hygiene. Competencies were completed with staff coinciding with the educational session.</p> <p>Audits of nebulizer treatments and handwashing will take place weekly x 4 to assure compliance. Results will be reported to the QAPI committee by the Nurse manager for 3 months.</p> <p>Date of Correction: September 15, 2016.</p> <p>Responsible: DNS, Nurse Managers</p> <p><i>F441 POC accepted 9/29/16 BBOR/RN/PM</i></p>	
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{F 441}	Continued From page 2 the resident, obtained the nebulizer mask from a bag in the resident's dresser, put the liquid nebulizer medication in the medication chamber, placed the nebulizer mask over the resident's nose and mouth, turned the nebulizer machine on to start the treatment and left the resident's room. The LPN did not wear gloves for the nebulizer medication administration. The LPN also did not wash his/her hands after the medication administration and/or prior to leaving the resident's room. The LPN proceeded down the hallway and into a charting room to speak to another staff member. Per interview on 9/14/16 at 12:17 PM with the LPN, s/he confirmed that s/he did not wash his/her hands after the nebulizer medication administration and/or prior to leaving Resident #3's room. Per review of the Medication Administration Nebulizers (Updraft) policy, last updated 9/10, Step 2 of the procedure states, "Assemble equipment and supplies on the resident's over-bed table, with a barrier between supplies/medication and table." Step 3 states, "Perform Hand Hygiene." Step 21 of the procedure states, " Rinse and disinfect the nebulizer equipment according to manufacturer's recommendations and facility policy." Step 22 of the procedure states, "Wash hands thoroughly". Per interview on 9/14/16 at 1:26 PM with the Nurse Educator/Infection Control Nurse, s/he stated the nursing staff were aware that there was a policy for medication administration with nebulizers and that the nursing staff received education regarding medication administration with nebulizers during orientation.	{F 441}			