STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475033	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crescent Manor Care Ctrs	312 Crescent Blvd Bennington, VT 05201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by another resident for 1 of 3 residents sampled [Resident #2]. Findings include:Per record review, Resident #1's diagnoses include unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, Anxiety, and cognitive communication deficit. Resident #2's diagnoses include Alzheimer's and dementia. Both residents had a BIMS score (Brief Interview for Mental Status) of 99, which indicates they were unable to answer questions to determine their cognitive functional level. Per regulation guidelines Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions . it is important to remember that abuse includes the term willful. The word willful means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. An example of a deliberate (willful) action would be a cognitively impaired resident who strikes out at a resident within his/her reach.Per review of the facility's investigation of the resident-to-resident incident on 8/18/25, A Licensed Nursing Assistant [LNA] saw Resident #1 standing over Resident #2's bed. When the LNA asked Resident #1 what s/he was doing, Resident #1 turned to Resident #2 and made contact with Resident #2's forehead with a closed fist. Resident #1 was immediately re-directed to another area. Resident #2 is unable to speak h/her needs. Per facility report the allegation was verified, as it was witnessed to have occurred by a staff Licensed Nursing Assistant.An interview was conducted with the facility's Director of Nursing [DON] on 9/8/25 at 12:46 PM.The DON confirmed that the facility failed to ensure Resident #2 was free from physical abuse when Resident #1 struck Resident #2 on 8/18/25.

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.

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