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	12/17/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to implement care plan interventions to reflect an identified concern for 1 of 3 sampled residents (Resident #1) related to the use of wheelchair leg rests. Findings include:Per record review, Resident #1 has diagnoses that include multiple sclerosis, (MS; a disease that heavily affects postural control, predisposing patients to accidental falls and fall-related injuries), dementia, anxiety disorder, and major depressive disorder. Resident #1 has a BIMS score (Brief Indicator for Mental Status, a test to check if thought processes are intact) of 12 out of 15, indicating moderate cognitive impairment.Per record review, Resident #1 has limited physical mobility related to her/his MS and weakness. Resident #1's care plan states LOCOMOTION: [She/he] requires (Extensive assistance) by (1) staff for locomotion using standard chair and bilateral footrests PRN [as needed], created on 10/27/25. A 12/8/25 risk management report reveals that Resident #1 had a fall while being pushed in a wheelchair because his/her foot got caught under the wheelchair. See F689 for more information. Resident #1's care plan was revised to include ensure leg rests are on when in w/c.Per observation of Resident #1 on 12/17/25 at 12:35 PM, Resident #1 was in her/his room, sitting in her/his wheelchair, with no leg rests attached. Per interview, when asked about the incident, Resident #1 stated that the staff member was pushing his/her wheelchair very fast, and they could not keep up, and fell.Per interview with LPN #1 on 12/17/25 at 12:40 PM, she/he confirmed that the resident was sitting in their wheelchair and did not have leg rests attached. LPN #1 additionally confirmed that Resident #1 was to have leg rests on when in her/his wheelchair.Per interview on 12/17/25 at 12:00 PM, the DON (Director of Nursing) confirmed that Resident #1 does not self-propel in her/his wheelchair. The DON stated it is facility policy that residents who cannot self-propel in their wheelchair must be ambulated using footrests. The DON confirmed that Resident #1 was care planned to use bilateral footrests and she/he cannot self-propel, the footrests should have been in place at the time of the fall on 12/8.

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

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	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to ensure residents remained as free from accidents as possible related to falls for 1 of 3 sampled residents (Resident #1) by failing to ensure assistive devices were provided and failing to implement interventions that would reduce the likelihood of future falls. As a result, Resident #1 suffered a fall that resulted in redness, swelling, and abrasions to the front of the left knee and back of the right hand. Findings include:Per record review, Resident #1 has diagnoses that include multiple sclerosis, (MS; a disease that heavily affects postural control, predisposing patients to accidental falls and fall-related injuries), dementia, anxiety disorder, and major depressive disorder. Resident #1 has a BIMS score (Brief Indicator for Mental Status, a test to check if thought processes are intact) of 12 out of 15, indicating moderate cognitive impairment.Per record review, Resident #1's care plan reveals that she/he needs assistance or is dependent on staff to perform activities of daily living (ADLs) and uses a wheelchair. Her/his care plan includes the focus [Resident #1] has the potential for falls related to: dx [diagnosis] of multiple sclerosis, syncope (fainting) and collapse, disorder of the autonomic nervous system, and HTN (high blood pressure), created on 10/28/25. Additionally, Resident #1's care plan states LOCOMOTION: [She/he] requires (Extensive assistance) by (1) staff for locomotion using standard chair and bilateral footrests PRN [as needed], created on 10/27/25.Per a risk management report of a witnessed fall dated 12/8/25 reads, LNA [Licensed Nursing Assistant] was driving resident in the wheelchair and resident's foot got caught on the wheelchair and [she/he] fell from the wheelchair. The LNA's statement from the risk management report reads, While I was pushing the resident in wheelchair to shower room, resident's foot got caught underneath wheelchair with resident going to floor.In an interview with Resident #1 on 12/17/25 at 12:35 PM, when asked about the incident, s/he stated that the staff member was pushing his/her wheelchair very fast, and they could not keep up, and fell.A progress note written by the Practitioner, dated 12/8/25, notes the injuries sustained in the fall included abrasions to the left knee and right hand.In an interview with the DON (Director of Nursing) on 12/17/25 at 11:50 AM, the DON stated that it is facility practice to have leg rests in place when ambulating residents that do not self-propel. The DON confirmed that Resident #1 requires assistance and does not self-propel. The DON was unable to produce evidence that facility staff had been educated about the use of wheelchair leg rests as a facility practice for residents that do not self-propel.(National Institutes Of Health, Spotlight on postural control in patients with multiple sclerosis 4/3/2018)