

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 06/16/2026
NAME OF PROVIDER OR SUPPLIER Crescent Manor Care Ctrs		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Per interview and record review, the facility failed to notify resident representative of alleged abuse of 1 of 1 residents (Resident #1). Findings include: Per review of the Facility's 5-day internal investigation dated xx, an allegation that Licensed Nursing Assistant #1 slapped Resident #1 was investigated. A progress note dated 5/25/26 at 10:16 PM written by the Nursing Supervisor stated a report was received from a Licensed Nursing Assistant (LNA) who witnessed an altercation between LNA #1 and Resident #1, and that the Director of Nursing (DON) and Power of Attorney were notified. Per record review of the Facility's Incident Report prepared by the Nurse Supervisor, the residents Family Member was notified of the incident at 7:35 PM on 5/25/26. Per record review, Resident #1's family member is their Power of Attorney. Per interview on 6/16/26 9:42 AM with Resident #1's Power of Attorney, they stated they were notified of an altercation. They described the notification to include Resident #1 had increasing behaviors that night, was aggressive towards staff, and was then redirected. The Power of Attorney confirmed they were not informed of the allegation that LNA #1 slapped Resident #1. They further stated they have been to a care plan meeting since the incident on 6/9/26 and the alleged abuse was not discussed in the meeting. Per interview on 6/16/26 at 10:37 AM with the Nurse Supervisor who prepared the Incident Report, they confirmed they called the residents Power of Attorney and notified them of an altercation between staff and Resident #1. The Nurse Supervisor confirmed they did not notify the Power of Attorney of the allegation of staff to resident physical abuse. Per interview with the Administrator and Director of Nursing on 6/16/26 at approximately 11:30 AM, they confirmed that the residents responsible party should be notified of alleged abuse.		

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