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	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crescent Manor Care Ctrs	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to ensure a safe clean homelike environment for the residents who reside on the licensed memory care unit. Findings include:1. During the initial tour of the licensed memory care unit (North Unit) on 1/5/2026 at 11:30 AM, there was a sharps container fastened to the wall in the shower room. The container was full and unable to close properly. There was a bundle of disposable razors on the top of the sharps container held together with a rubber band and three of the razors had no covers on them. Per interview with a Licensed Practical Nurse (LPN) on 1/7/2026 at approximately 1:00 PM, she confirmed that the sharps container was full and should have been removed. She also confirmed that the disposable razors should not have been left on top of the sharps container. 2. During observations of the North Unit 1/5/2026 at 12:44 PM in the dinning/activity room located near the nursing station, the baseboard radiator was noted to have three areas at different points of the system that were uncovered exposing the sharp fins. Per interview on 1/7/2026 at 9:20 AM, the Unit Manager (UM) confirmed the areas of the radiator were not covered and the sharp pieces were exposed. The UM contacted the Maintenance Director who responded to the dining room and stated that the radiators will be replaced soon and that the covers get bumped off.

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interviews and record reviews, the facility failed to support the residents' right to file grievances anonymously. This has the potential to affect all residents at the facility. Findings Include:Per observation, the facility's bulletin board in the lobby area displayed the grievance policy and procedure in a document protector, with only the first page visible. The document included the grievance officer and contact information, but did not provide details on how to file a grievance anonymously. There is no evidence of the option to file an anonymous grievance, nor is there any indication on the grievance forms that this is an option. Review of the facility policy, titled Crescent Manor Rehabilitation Grievance Policy and Procedures, no date, found that the procedures state the resident must sign the form. The form attached to the policy also requires a resident's signature. Per interview on 1/6/26 at 1:10 PM with three residents, Resident #7, a resident at the facility for several years, stated that if a resident wants to file a grievance, they use the facility-provided form and give it to the Social Worker. S/he does not know of a system within the facility that allows the resident to file the grievance without revealing the writer's identity. Resident #81, who has been a resident for the past several months, was also unable to identify the process for filing an anonymous grievance. Neither resident can recall a system to keep the process anonymous. Per interview on 1/6/26 at approximately 2:34 PM with the Social Worker, identified in the policy and procedure as the designated Grievance Official, she indicated the facility uses the envelope located by the grievance forms for anonymous grievances. She confirmed that the policy and procedure document on display doesn't include a process for filing a grievance anonymously. The Social Worker confirmed she was unable to locate it in the policy and procedures and stated it was very difficult if someone files an anonymous grievance, and confirmed it is a requirement to have the option of filing a grievance anonymously.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure medications were removed from the medication storage rooms and treatment rooms when expiration dates were reached for 3 out of 3 rooms. Findings include: Per review of the facility policy titled Storage of Medication dated 1/24, it states that Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock .Per observation and interview on [DATE] at approximately 9:56 AM in the west wing medication room, the Unit Manager confirmed the following items were expired: three administration sets of priming IV tubing kits with an expiration date of [DATE], eight containers of ten milliliter sterile water for injection with an expiration date of [DATE], Piperacillin and Tazobactam for injection 3.375 grams for IV use with an expiration date of 3/25, Epinephrine 0.3 mg single auto injectors with an expiration date of 3/25, BD Vacutainer safety-lok blood collection set with an expiration date of [DATE], four BD max plus clear needleless connectors with an expiration date of [DATE]. The Unit Manager also confirmed a bottle of glucose tablets that did not have an expiration date and stated that anything without a date should be thrown out.Per observation and interview on [DATE] at 10:13 AM in the north wing medication room, a Licensed Practical Nurse confirmed that a bottle of Vitamin B-Complex did not have an expiration date and that it should be thrown out.Per observation and interview on [DATE] at 10:20 AM, in the medication treatment room near the south/west nursing station, the Nursing Manager confirmed the following items were expired: four Proven (Post insertion foley care wipes) with an expiration date of [DATE], ninety skin protectant ointments with an expiration date of 5/25, and one Intermittent 14 French catheter kit with an expiration date of [DATE].

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on interview and record review, the facility failed to promptly notify the provider of laboratory results that fell outside of clinical reference ranges for 1 of 1 residents (Resident #27). Findings include: Per review of the facility's policy titled Notification of Changes Policy dated 11/25, it states The purpose of the policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the residents representative when there is a change requiring notification. The policy additionally identifies that when a resident has a significant change in physical condition that the provider should be notified.Per review of the facility's policy titled Laboratory Services and Reporting dated 2020, it states to Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside the clinical reference range.Per record review, a progress note dated 1/5/26 at 7:15 PM, identified that Resident #27 had a critical sodium level of 161. There is no note indicating that the provider was notified immediately after nursing staff were informed of the critical lab value. A Nurse Practitioner note dated 1/6/26 at 8:30 AM, identified that Resident #27 had severe hypernatremia with sodium of 161 and that this was a critical condition and that s/he was sent to the emergency department for expedited evaluation and management.Per interview with a Licensed Practical Nurse (LPN) on 1/7/26 at 8:32 AM, she confirmed that the provider and Director of Nursing (DON) were not immediately made aware that Resident #27 had a critical lab value, and that as soon as the Nurse Practitioner was made aware, she sent out the Resident to the Emergency Department. The LPN confirmed that a provider should be notified right away of critical lab values.Per interview with the DON on 1/7/26 at 8:37 AM, she confirmed that the provider should have been notified of the critical lab value at the time the nurse was notified of the lab value.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and policy reviews, the facility failed to store food in accordance with professional standards for food service safety. This deficiency has the potential to impact all residents in the facility. Findings include:1. During initial tour of the kitchen's dry storage area on 1/5/26 at approximately 11:00 AM with the Food Service Manger (FSM), revealed boxes of condiments containing individual servings of saltines, salad dressings, and catsups that did not have expiration dates on the boxes. Also observed in the dry storage room were (5) 5# bags of Devil's Food cake, (4) 5# bags of brownie mix, (12) 5# bags of white cake mix, (2) 5# bags of basic muffin mix, all with no expiration dates on the packages. The FSM stated that they did not know what the expiration dates of these food items were because the original boxes had been thrown away. There were 4 racks of bread in the hall of the dry storage area that had no expiration dates. Per interview with the FSM on 1/5/26 during the tour of the dry storage area, confirmed that the condiments did not have expiration dates on the boxes and they could not provide them. The FSM confirmed the mixes did not have expiration dates and the boxes that the mixes came in had been thrown away. The FSM confirmed that the (4) racks of bread did not have expiration dates. 2. Observation of the kitchen area on 1/5/26 at approximately 11:15 AM it was noted that a commercial can opener and meat slicer were not clean. The can opener blade was covered in a thick, sticky, wet, black substance, and dried red substance near blade and on the bracket of the can opener. The meat slicer appeared to have been wiped down, however upon further inspection the meat tray was noted to be dry but with gritty residue and specks of a dried light pink substance. The back of the blade was noted to have a dried light pink colored substance dried/stuck on that was easily scraped off. Per interview on 1/5/26 at approximately 11:17 PM, the FSM confirmed the can opener was not clean and should have been put through the dishwasher and stated the staff probably used the meat slicer this morning and that it was not clean. 3. Observation of the freezer on 1/5/26 at approximately 11:40 AM revealed (4) packages of 12 count hot dog rolls with no expiration dates, and 1 box of [NAME] fish sticks with no expiration date. Interview on 1/5/26 at approximately 11:41 AM, the FSM and dietician confirmed the hot dog rolls and box of [NAME] fish sticks had no expiration dates. 4. Observation on 1/5/26 at approximately 2:45 PM, the South Unit kitchenette refrigerator freezer contained a pink substance in a clear plastic cup with a dome lid containing a straw that was covered with a piece of paper towel that was not labeled with a resident's name or an expiration date. Interview on 1/5/26 at approximately 2:50 PM with the Activities Director, they confirmed the pink substance in the cup should not be in the resident's refrigerator freezer and should be thrown out as it did not belong to a resident and could have been brought in by family or may have belonged to staff. 5. Observation on 1/6/26 at approximately 8:15 AM observation of the [NAME] Unit kitchenette revealed (2) containers with lids containing foods that were not dated with preparation date or expiration date. Also identified was a loaf of white bread that was not dated with either an expiration date or an opened date. Various individual sized condiments and snacks (Oreo's, Fig Newtons, oatmeal bars, saltines, graham crackers, catsup, maple syrup, mayonnaise, honey, and peanut butter) were noted in bins with no expiration dates. Interview on 1/6/26 at approximately 8:20 AM with an LPN working on the [NAME] Unit confirmed the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to ensure staff were appropriately wearing Personal Protective Equipment (PPE) for 2 of 2 units. This is a repeat deficiency for this facility, with violations cited during the previous recertification surveys, dated 10/2/24.Findings include:1. Per observation on 1/5/26 at approximately 2:15 PM, LNA #1 was noted sitting behind the west nurse's station without a mask. LNA #1 left the nurses station, proceeded down the hall with LNA #2, engaging in conversation. LNA #1 was noted to have a disposable mask swinging from their wrist and mid hallway placed the mask on and worn under their chin. Per interview on 1/5/26 at approximately 2:25 PM with LPN #1, they confirmed LNA #1 was not wearing their mask correctly and that masks were required at that time due to an active Covid outbreak. 2. Per observation on 1/6/26 at approximately 4:35 PM of the west unit nurse's station, RN #1 was noted to be wearing their mask under their chin. Per interview on 1/6/26 at 4:47 PM, the Administrator confirmed that all staff are required to wear masks when on the units, even behind the nurse's station. 3. Observations on 1/5/26 on the facility's memory care unit revealed multiple direct care staff [licensed nurses' aides] wearing face masks incorrectly, with the face masks positioned below their noses. An interview was conducted with the Infection Preventionist on 1/7/26 at 9:15 AM. The IP confirmed that due to an outbreak of COVID 19 [Coronavirus disease] in the facility there was universal masking for the building [all staff wearing medical masks at all times] to prevent the spread of infection. The IP confirmed that there were multiple observations of facility staff not wearing masks or wearing them incorrectly where the masks do not provide protection from infection for the residents or the wearer. According to the Mayo Clinic: The virus that causes COVID-19 spreads mainly through the air when a person coughs, sneezes, sings, talks or breathes.face masks or respirators are products that cover the nose, mouth and chin. Most research finds that these products can slow the spread of the virus that causes COVID-19 when they are worn consistently, fit properly and are worn correctly. (https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/coronavirus-mask/art-20485449)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview and record review, the facility failed to ensure a call system allowing residents to call for staff assistance is accessible to residents while in their bed or other sleeping accommodations within 5 out of 6 rooms for residents Care Planned for call bell use. The facility also failed to ensure that an alternate means of communicating with staff was provided after removing the call light from the resident's room for Resident #35. Findings include: 1). Per observation on 1/5/25 at 11:46 AM and again on 1/6/26 at 4:08 PM, the corded call bells for both resident beds in rooms #1, #4, and #5, were hanging on the walls out of reach of the residents in their beds, and the call bell out of reach for 1 resident in room [ROOM NUMBER]. An interview was conducted with the residents' Unit Manager [UM] on 1/7/26 at 8:25 AM. The Unit Manager stated that most residents in the Special Care Unit are not able to use the call bell system. Per record review, the Care Plans for at least one resident in rooms 1 [Resident #68 and Resident #53], room [ROOM NUMBER] [Resident #20], room [ROOM NUMBER] [Resident #22] and room [ROOM NUMBER] [Resident #54] contain interventions that include Be sure the resident's call light is within reach and encourage the resident to use it and/or Be sure call light is within reach and respond promptly. An interview was conducted with Resident #68 on 1/5/26 at 12:10 PM. Resident #68 was asked how s/he alerts staff when s/he needs assistance. The resident replied There is a button here somewhere. I don't know where it is. Per record review, a nursing admit/readmit note on 8/13/25 at 1:20 PM, reads [Resident #68] verbalizes/ demonstrates the use of the call bell. Per observation, both Resident #68's and Resident #53's call bells were hanging on the wall between the resident's and the roommate's bed, hidden behind a curtain. Per record review, progress notes dated 10/10/25 reveal Resident #22 demonstrated use of their call bell. The progress note records Resident pulled [her/his] bathroom call bell, so an LNA [Licensed Nursing Assistant] checked [her/him] . An interview was conducted with Resident #22 on 1/5/26 at 12:22 PM. The resident was asked how s/he alerts staff when s/he needs assistance. Resident #22 replied, There is a thing you push. The resident was unable to locate the call bell. Per observation, both Resident #22's and their roommate's call bells were hanging on the wall between the resident's and the roommate's bed, hidden behind a curtain. An interview was conducted with the Unit Manager [UM] on 1/7/26 at 8:23 AM. The UM confirmed that the call bells for the 5 residents in the 4 rooms listed above were out of reach and unavailable for use to the residents. The UM confirmed that the 5 residents were care planned to ensure the resident's call light is within reach and encourage the resident to use it and that residents #68 and #22 had documented ability to use the call bells. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4 . Per record review Resident #35 has diagnoses that include dementia, wandering, delusional disorders, adjustment disorders, depression, anxiety disorder, and major depressive disorder. Review of her/his care plan reveals that s/he is incontinent of bowel and bladder and self-transfers and ambulates. During unit observations on 1/6/2025 at 12:30 PM, Resident # 35's call light cord was noted to be missing from the call light box on their wall. Further observation of the room revealed that there was no alternate means for the Resident to communicate with the staff if needed. Review of Resident #35's care plan reveals a focus initiated on 7/31/2023 states that the Resident is at risk for a communication problem r/t dementia with an intervention also initiated on 7/31/2023 of Ensure/provide a safe environment: Call light in reach,,, A progress Note dated 5/25/2024 reads Resident was observed this shift to be disconnecting [her/his] call light from the wall x3 and when nursing staff redirected resident to give the writer the extension cord to plug back into the wall, resident became verbally aggressive towards nursing staff. Resident was yelling and using abusive language making it difficult to communicate. physical attempt to approach resident to retrieve extension cord were met with punches from resident to nursing aide. resident stated if this writer doesn't leave [s/he] will hit her too. writer kept a safe distance from resident. resident was given time to calm down and writer re-approached after couple of minutes. writer contacted [on call provider] to inform her of resident's behavior and to seek further instructions. NP [Nurse Practitioner] gave orders to administer one time dose of olanzapine [antipsychotic medication] 5mg po for agitation. orders initiated. A care plan focus that was last revised on 7/31/2023 states that the Resident is at risk for an ADL [activities of daily living] self-care performance deficit r/t dementia, and has an intervention initiated on 9/19/2024 of [Resident] cannot use call bell appropriately. Staff must anticipate needs. Resident #35's Kardex (a document that is based on the care plan and is used to communicate resident specific care needs) also states that the Resident cannot use call bell appropriately. Staff must anticipate needs. Further review of the care plan and Kardex revealed that there was no alternate means of communicating with the staff if needed put into place when the call light was removed. Per interview on 1/6/2026 at 1:50 PM the Maintenance Director confirmed that Resident #35's call light had been removed from the wall. He stated that it was removed a long time ago because s/he was pulling it out of the wall constantly. 2. During a Resident interview on 1/6/2026 at 1:30 PM Resident #9 was asked how s/he would get help from staff if s/he needed it. The Resident stated that s/he would use their call light and went to reach for it. The call light was noted to be on the floor under the bed. The Resident asked if I could pick it up and give it to her/him. The Resident then pushed the button to demonstrate that s/he can utilize the call light. 3. During unit observations on 1/7/2026 at 9:25 AM Resident #81 was observed sleeping in their bed. The bed was positioned with the left side against the wall. The call light was noted to be hanging from the wall behind the side of her bed out of reach from the Resident. A Licensed Nursing Assistant (LNA) who was passing by the room was asked how the Resident would call for assistance the LNA confirmed that the call light was not in the Resident's reach. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per interview with the Staff Development Coordinator (SDC) on 1/07/2026 at 11:20 AM, staff are educated that when they bring residents to their rooms they need to make sure that the call light is in the resident's reach. Staff are also educated to answer call lights immediately and provide the needed assistance. The SDC confirmed that call light cords should not be pinned up out of reach or completely removed from the wall.