VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

January 16, 2026

Ms. Shannon McHale, Administrator
Crescent Manor Care Ctrs
312 Crescent Blvd
P.O. Box 170
Bennington, VT 05201

Provider ID #: 475033

Dear Ms. McHale:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **December 17, 2025.** 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
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crescent Manor Care Ctrs	312 Crescent Blvd P.O. Box 170, Bennington, Vermont, 05201

(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
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of one complaint and one facility reported incident, including report(s) #2608894 and 2604533, on 12/17/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F0000		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F0656	**F-656- Development/Implement Comprehensive Care Plan** **I. The following actions were accomplished for the residents identified in the sample:** The care plan for Resident #1 was reviewed and revised. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** All residents using wheelchairs that do not self-propel had the potential to be impacted by this deficient practice. The facility Wheelchair Transportation policy was reviewed, without revision. A full house audit was conducted to ensure all residents using wheelchairs that do not self-propel were issued leg rests and that their care plan reflected the use of leg rests when in their wheelchair.	

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 reverse for further 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
	Administrator	01/06/26

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F0656 SS = D	Continued from page 1 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: 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	F0656	**III. The following system changes will be implemented to ensure continuing compliance with regulations:** Staff responsible for assisting patients with transport were re-educated on the facility Wheelchair Transportation policy. Nursing Staff were educated on resident #1's updated care plan. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** Observations audits to ensure residents in wheelchairs that do not self-propel have leg rests on when in their wheelchairs will be conducted weekly x 4 weeks and monthly x 3 months to ensure resident safety. Results of the audits will be reviewed in the QAPI committee meeting x 4 months for further resolution if needed. **Completion Date:** **___01/07/2026_____** **Responsibility: Director of Nursing** **Tag F 656 POC accepted on 1/15/26 by S. Freeman/S. Stem**	

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F0656 SS = D	Continued from page 2 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.	F0656		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 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	F0689	**F-689- Free of Accident Hazards/Supervision/Devices** **I. The following actions were accomplished for the residents identified in the sample:** The care plan for Resident #1 was reviewed and revised. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** All residents using wheelchairs that do not self-propel had the potential to be impacted by this deficient practice. The facility Wheelchair Transportation policy was reviewed, without revision. LNA who was involved in 12/8/25 cited incident was re-educated on the Wheelchair Transportation policy with return demonstration of pushing the wheelchair at an appropriate pace for the safety of the residents.	

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F0689 SS = D	Continued from page 3 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)	F0689	**III. The following system changes will be implemented to ensure continuing compliance with regulations:** Staff responsible for assisting patients with transport were re-educated on the facility Wheelchair Transportation policy, specifically the use of leg rests as a facility practice for residents that do not self-propel. Nursing Staff were educated on resident #1's updated care plan. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** Observations audits to ensure residents in wheelchairs that do not self-propel have leg rests on when in their wheelchairs will be conducted weekly x 4 weeks and monthly x 3 months to ensure resident safety. Results of the audits will be reviewed in the QAPI committee meeting x 4 months for further resolution if needed. Completion Date: **____01/07/2026_____** Responsibility: Director of Nursing **Tag F 689 POC accepted on 1/15/26 by S. Freeman/S. Stem**	