VERMONT

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

January 29, 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 recertification survey conducted on **January 7, 2026.** 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 01/07/2026

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
E0000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 1/7/26. There were no regulatory violations identified.	E0000		
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey from 1/5/2026 through 1/7/2026 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F0000		
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F0584	**F-584- Safe/Clean/Comfortable/Homelike Environment** **I. The following actions were accomplished for the residents identified in the sample**: There were no residents identified in the sample. The sharps container fastened to the wall in the shower room that was full and unable to close properly was removed and replaced with an empty container. The bundle of disposable razors on the top of the sharps container held together with a rubber band was removed and discarded. The baseboard radiator in the dining/activity room noted to have three areas at different points of the system that were uncovered exposing the sharp fins was replaced. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** The Administration of Injections Policy was reviewed without revision.	

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: Administrator	(X6) DATE: 01/28/2026

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F0584 SS = E	Continued from page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: 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.	F0584	All residents in the memory care unit had the potential to be impacted by the deficient practice. No additional residents were found to be affected by the deficient practice. A full house observation audit of all Sharps containers was conducted. Any full containers identified were replaced. A full house observation audit of all baseboard radiators was conducted. Any baseboard radiators that were noted to have uncovered exposed areas were replaced. **III. The following system changes will be implemented to ensure continuing compliance with regulations:** Checking the baseboard radiators and other heaters to ensure they are intact was added to the Monthly Environmental Checklist. Maintenance staff will be educated on the updated checklist. Nursing staff were re-educated on the Administration of Injections policy with focus on changing out Sharps containers when they reach the fill line. All nursing staff were re-educated to not store or secure anything on top of the Sharps containers. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** The Baseboard Radiators were added to the Preventative Maintenance/Environmental Rounds monthly checklist. Observation audits to ensure the baseboard radiator covers are in place will be conducted weekly x 4 weeks and monthly going forward. Observation audits to ensure Sharps containers are changed when they have reached the fill line will be conducted weekly x 4 weeks and monthly x 4 months. Results of the audit will be reviewed in the QAPI committee meeting x 4 months with further review if needed.	
F0585 SS = E	Grievances	F0585		

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F0585 SS = F	Continued from page 2 CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by	F0585	**Completion Date:** **___01/31/2026_____** **Responsibility: Director of Maintenance for Radiators/Director of Nursing for Sharps** **Tag F 584 POC accepted on 1/29/26 by J.Schneckenburger/S. Stem** **F585 - Grievances** **I. The following actions were accomplished for the residents identified in the sample**: The Grievance Policy and Procedure and associated form was reviewed and updated to include details on how to file a grievance anonymously. Resident #7 was educated on the updated Grievance Policy and Procedure with an emphasis on how to file a grievance anonymously, should the resident choose to do so. Resident #81 (BIMS 5) residing on the memory care unit was educated on the updated Grievance Policy and Procedure with an emphasis on how to file a grievance anonymously, should she choose to do so. Given the resident's low cognitive function score, the resident's responsible party was contacted and provided the same education. The updated Grievance Policy & Procedure, and associated form were posted page by page on the bulletin board, making each page visible. The updated Grievance Policy & Procedure was added to the Admissions Packet. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** Any resident wanting to file a grievance had the potential to be impacted by the deficient practice. No additional residents were found to be affected by the deficient practice. A Resident Council meeting was held to review the revised Grievance Policy & Procedure, associated form and where to find the posted policy and form with an emphasis on how to file a grievance anonymously, should they choose to do so.	

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F0585 SS = F	Continued from page 3 the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: 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	F0585	The Social Worker educated those residents unable to attend the Resident Council meeting on the revised Grievance Policy and Procedure, associated form and where to find the posted policy and forms with an emphasis on how to file a grievance anonymously. An automated call was placed to all family members/responsible parties advising them of the revised Grievance Policy and Procedure, where to find the policy at the facility or how to request a copy. **III. The following system changes will be implemented to ensure continuing compliance with regulations:** All Staff & Residents were educated on the revised Grievance Policy & Procedure, associated form, where the policy & forms are located/posted, with an emphasis on how a resident can file a grievance anonymously. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** The Social Worker will monitor the submitted grievances weekly x 4 weeks and monthly x 3 months to ensure any anonymously submitted grievances are brought to resolution. The Activities Director will discuss the grievance process in the Social Services section of Resident Council meetings monthly x 4 months to ensure that all residents have an understanding of the grievance process, their right to file a grievance anonymously and where to find the posted policy and form. Results of the audit will be reviewed in the QAPI committee meeting x 4 months with further review if needed. **Completion Date:** **____01/31/2026_____** **Responsibility: Administrator** **Tag F 585 POC accepted on 1/29/26 by J. Schneckenburger/S. Stem**	

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F0585 SS = F	Continued from page 4 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.	F0585		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F0761	**F-761 Label/Store Drugs and Biologicals** **I. The following actions were accomplished for the residents identified in the sample:** No residents were identified in the sample. All expired medications/items were removed from the West Wing medication room and discarded.	

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F0761 SS = E	Continued from page 5 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: 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 1/6/26 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 5/7/25, eight containers of ten milliliter sterile water for injection with an expiration date of 10/1/25, 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 3/31/25, four BD max plus clear needleless connectors with an expiration date of 6/25/24. 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 1/6/26 at 10:13 AM in	F0761	All expired medications/items were removed from the North Wing medication room and discarded. All expired medications/items were discarded from the medication treatment room near the South/West nursing station. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** All residents had the potential to be affected by the deficient practice. No residents were found to be affected by the deficient practice. An audit was conducted of all medication/treatment rooms and medication/treatment carts. All expired medications or expired items were discarded. **III. The following system changes will be implemented to ensure continuing compliance with regulations:** The Storage of Medication policy was reviewed without revision. All nurses were re-educated on the Storage of Medication policy. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** All medication/treatment rooms and carts will be audited weekly x 4 weeks and monthly x 4 months to ensure expired medications/items are discarded. Results of the audit will be reviewed in the QAPI committee meeting x 4 months with further review if needed. **Completion Date: ____01/31/2026_____** **Responsibility: Director of Nursing_____** **Tag F 761 POC accepted on 1/29/26 by J. Schneckenburger/S. Stem**	

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F0761 SS = E	Continued from page 6 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 1/6/26 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 8/31/24, ninety skin protectant ointments with an expiration date of 5/25, and one Intermittent 14 French catheter kit with an expiration date of 9/30/25.	F0761		
F0773 SS = D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is NOT MET as evidenced by: 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	F0773	**F773- Lab Srvcs Physician Order/Notify Results** **I. The following actions were accomplished for the residents identified in the sample**: Resident #27 was sent to the Emergency Room to address the clinical lab value. The resident received IV fluids, antibiotics and follow up monitoring. The resident returned to the facility. The care plan for Resident #27 was updated. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** An audit of the lab results received for the previous week was conducted to ensure that there were no other critical lab values that should have been reported to the provider. There were no further critical values found. No other residents were identified as having been affected by this deficient practice.	

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F0773 SS = D	Continued from page 7 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.	F0773	**III. The following system changes will be implemented to ensure continuing compliance with regulations:** The Notification of Changes Policy was reviewed without revision. The Lab Services Reporting Policy was reviewed without revision. All nurses were re-educated on the Notification of Changes Policy and the Lab Services Reporting Policy to ensure prompt notification of a provider upon receipt of a critical lab value. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** Lab results will be audited weekly x 4 weeks and monthly x 3 months to ensure prompt notification of a provider upon receipt of a critical lab value. Results of the audit will be reviewed in the QAPI committee meeting x 4 months for further resolution if needed.	
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F0812	**Completion Date: 01/31/2026** **Responsibility: Director of Nursing** **Tag F 773 POC accepted on 1/29/26 by J. Schneckenburger/S. Stem** **F-812- Food Procurement, Store/Prepare/Serve-Sanitary** **I. The following actions were accomplished for the residents identified in the sample:** No residents were identified in the sample. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** No residents were found to be affected by the deficient practice.	

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F0812 SS = F	Continued from page 8 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: 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 pollack	F0812	All boxes of condiments containing individual servings of saltines, salad dressings, and catsups that did not have an expiration date on the box were discarded. The five bags of Devil's Food cake, 4 bags of brownie mix, 12 bags of white cake mix and 2 bags of basic muffin mix without expiration dates were discarded. The 4 racks of bread in the hall of the dry storage area that had no expiration dates were discarded. The 4 packages of 12 count hot dog rolls with no expiration dates and 1 box of pollack fish sticks with no expiration dates found in the freezer were discarded. The pink substance in the plastic cup with a dome lid containing a straw that was covered with a piece of paper towel not labeled or dated found in the South Unit kitchenette was discarded. The 2 containers with lids containing foods that were not dated with preparation dates or expiration dates located in the West Unit kitchenette were discarded. The loaf of white bread that was not dated with either an expiration date or an opened date in the West Unit kitchenette was discarded. The various individual sized condiments and snacks in bins without expiration dates found in the West Unit kitchenette were discarded. The commercial can opener and meat slicer found to be not cleaned, were cleaned. A full house audit was conducted of all storage areas in the kitchen, all kitchenettes and all refrigerators facility wide to ensure any items without proper labeling or expiration dates were discarded. An audit of the kitchen was conducted to ensure all equipment was properly cleaned. **III. The following system changes will be implemented to ensure continuing compliance with regulations:** The Date Marking for Food Safety Policy was reviewed and revised. Dietary staff will be re-educated on the Date Marking for Food Safety Policy and the Label and Dating procedure.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0812 SS = F	Continued from page 9 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 pollack 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 West 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 West Unit confirmed the above findings.	F0812	All Staff will be re-educated not to store personal food items in resident areas. The Sanitation Inspection of Food Service Areas policy was reviewed and revised. Dietary Staff will be re-educated on the Sanitation Inspection of Food Service Areas Policy. Dietary staff will be re-educated on the proper kitchen equipment cleaning procedures with return demonstration. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** Observation audits will be conducted weekly x 4 weeks and monthly x 3 months to ensure that food items are being stored and labeled properly in each designated area of the facility (kitchen, kitchenettes, dining/activity areas, refrigerators). Observation audits will be conducted weekly 2 4 weeks and monthly x 3 months to ensure kitchen equipment is clean. Results of the audit will be reviewed in the QAPI committee meeting x 4 months for further resolution if needed.	
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the	F0880	**Completion Date: ____01/31/2026_____** **Responsibility: Food Service Director** **Tag F 812 POC accepted on 1/29/26 by J. Schneckenburger/S. Stem** **F-880 – Infection Prevention & Control** **I. The following actions were accomplished for the residents identified in the sample**: No residents were identified in the sample. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** All residents had the potential to be affected by this deficient practice. There were zero additional cases of COVID-19 identified from staff or resident testing. Thus, no further residents were affected by the deficient practice.	

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F0880 SS = E	Continued from page 10 facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP	F0880	**III. The following system changes will be implemented to ensure continuing compliance with regulations:** The COVID-19 Outbreak Protocol was reviewed without revision. All Staff were re-educated on the COVID-19 Outbreak Protocol. All Staff were re-educated on properly wearing a mask when required with return demonstration. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** An audit will be conducted weekly x 4 weeks and monthly x 3 months to ensure that staff are wearing masks appropriately when required. Results of the audit will be reviewed in the QAPI committee meeting x 4 months for further resolution if needed. **Completion Date: ___01/31/2026_____** **Responsibility: Director of Nursing_____** **Tag F 880 POC accepted on 1/29/26 by J. Schneckenburger/S. Stem**	

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F0880 SS = E	Continued from page 11 and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: 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:	F0880		

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F0880 SS = E	Continued from page 12 "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)	F0880		
F0919 SS = E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: 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 #2. An interview was conducted with the residents' Unit	F0919	**F919 – Resident Call System** **I. The following actions were accomplished for the residents identified in the sample**: The corded call bells for both residents in rooms #1 (Resident #68 & Resident #53), #2 (Resident#20), #4(Resident #22), and #5(Resident #54) were placed within reach of the residents in their beds. Assessments for Use of Call Bell were completed for Residents #68, #53, #20, #22 and #54. The care plans and Kardex's for these residents were updated accordingly. A call light cord was installed in the call light box in Resident #35's room. An Assessment for Use of Call Bell was completed for Resident #35 and the care plan and Kardex for this resident was updated accordingly. The call bell for Resident #9 was placed within reach of the resident. An Assessment for Use of Call Bell was completed for Resident #9. The care plan and Kardex for Resident #9 was updated accordingly. The call bell for Resident #81 was placed within reach of the resident. An Assessment for Use of Call Bell was completed for Resident #81. The care plan and Kardex for Resident #81 were updated accordingly. The Special Care Unit Call Bell System Policy was reviewed without revision.	

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F0919 SS = E	Continued from page 13 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 2 [Resident #20], room 4 [Resident #22] and room 5 [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	F0919	**II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** All residents residing on the Dementia Special Care Unit had the potential to be affected by this deficient practice. Assessment for Use of Call Bell will be completed for all residents residing on the Dementia Special Care Unit. Each resident's care plan and Kardex will be updated accordingly. As stated in the Dementia Special Care Unit Call Bell policy, to accommodate the special needs of dementia residents that may not be able to use a call bell, the call bell will be attached to the bed to ensure accessibility and staff will consistently monitor the movement of residents and anticipate and meet the basic needs of the resident throughout the day. Each resident's care plan and Kardex will be updated accordingly. **III. The following system changes will be implemented to ensure continuing compliance with regulations:** All Direct Care staff working on the Dementia Special Care Unit and Maintenance staff will be re-educated on the Special Care Unit Call Bell system policy. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** An observation audit will be conducted weekly x 4 weeks and monthly x 3 months to ensure that call bells are attached to each resident's bed on the Dementia Special Care Unit. An audit will be conducted to ensure that assessments for use of call bells and associated updates for care plans and kardexes are completed for all residents admitted to the special care unit and those residents residing on the special care unit with a significant change in cognitive function weekly x 4 weeks and monthly x 3 months Results of the audit will be reviewed in the QAPI committee meeting x 4 months for further resolution if needed.	

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F0919 SS = E	Continued from page 14 use the call bells. 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	F0919	**Completion Date: 01/31/2026** **Responsibility: Director of Nursing** **Tag F 919 POC accepted on 1/29/26 by J. Schneckenburger/S. Stem**	

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F0919 SS = E	Continued from page 15 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. 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.	F0919		