VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

August 19, 2022

Ms. Kimberly Roberge, Manager
Craftsbury Community Care Center, Inc.
1784 East Craftsbury Road
Craftsbury, VT 05826-9519

Dear Ms. Roberge:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 24, 2022**. 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
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0292	A. BUILDING _____ B. WING _____	C 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRAFTSBURY COMMUNITY CARE CENTER, IN	1784 EAST CRAFTSBURY ROAD CRAFTSBURY, VT 05826

(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) COMPLETE DATE
R100	Initial Comments: An unannounced on-site investigation of a facility self-report was conducted by the Division of Licensing and Protection on 5/24/22. As a result of the investigation the following regulatory violations were identified:	R100		
R135 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 Assessment 5.7.b If a resident requires nursing overview or nursing care, the resident shall be assessed by a licensed nurse within fourteen days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete a Resident Assessment for one resident (Resident #1) within 14 days of admission. Findings Include: Per record review Resident #1 was admitted to the facility on 5/4/21. Resident #1's Resident Assessment Form indicated the date of his/her admission assessment was 6/4/21. A Registered Nurse employed by the facility signed the Resident Assessment Form and documented the admission assessment was signed as complete on 6/4/22. On 5/24/22 at 2:35 PM the Executive Director confirmed the Resident Assessment Form for Resident #1 was completed one month after his/her admission date.	R135	Resident Assessments will be completed by the RN within14 days of admission and made a priority over other nursing tasks. Executive Director will review chart to assure assessments are completed as required after each admission.	

R135 - R224 POC accepted - PMCD RN

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R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete a re-assessment of one resident (Resident #1) when mental health changes occurred. Findings include: Per record review Resident #1's diagnoses include Bipolar Disorder, Dementia, and Chronic Insomnia. On 2/11/22 Resident #1 began to demonstrate aggressive behaviors including physical assaults on staff and other residents. Nursing notes on 2/17/22 documented Resident #1's Primary Care Provider was notified of "poor sleeping patterns lately" and his/her Durable Power of Attorney (DPOA) was notified of recent changes in behavior. On 2/18/22 Resident #1's DPOA expressed concern that not sleeping well "may lead to a manic episode triggered by exhaustion". On 5/4/22 Resident #1 was removed from the facility by the State Police and issued an emergency discharge notice due to "assaultive, aggressive behaviors and risk of harm to others". At 2:35 PM on 5/24/22 the Executive Director confirmed a Resident Assessment Form	R136	Verbal cueing was used to assure reassessments occurred. Executive Director will now periodically review charts to assure reassessments occurr as required. Recent staff change has occurred and current RN has been assigned to assure all assessments are up to date and meet resident's current condition. Review of all charts will be completed by July 15, 2022.	

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R136	Continued From page 2 completed on 6/4/21 was the only Resident Assessment Form completed while Resident #1 resided at the Residential Care Home, and a reassessment did not occur when Resident #1's mental health declined.	R136		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to update a written plan of care describing the care and services necessary to maintain one resident's (Resident #1's) wellbeing based on his/her needs and abilities. Findings include: Per record review Resident #1's diagnoses include Bipolar Disorder, Dementia, and Chronic Insomnia. On 2/11/22 Resident #1 began to demonstrate aggressive behaviors including physical assaults on staff and other residents. Nursing notes on 2/17/22 documented Resident #1's Primary Care Provider was notified of "poor sleeping patterns lately" and his/her Durable Power of Attorney (DPOA) was notified of recent changes in behavior. On 2/18/22 Resident #1's	R145	Current RN is reviewing all charts to assure individual plans of care are in place and updated according to each individual resident's needs. Will be completed by July 15, 2022 Executive Director will review chart after admission assessment is complete to assure plan of care is in place. DON or Executive Director will periodically review plans of care to assure they are meeting current needs.	

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R145	Continued From page 3 DPOA expressed concern that not sleeping well "may lead to a manic episode triggered by exhaustion". On 5/4/22 Resident #1 was removed from the facility by the State Police and issued an emergency discharge notice due to "assaultive, aggressive behaviors and risk of harm to others". At 3 PM on 5/24/22 the Executive Director confirmed Resident #1's Plan of Care was not updated to include goals and interventions to address aggressive behaviors including checks for physical stressors such as lack of sleep until 4/21/22, ten weeks after Resident #1's aggressive behaviors and assaults on staff and residents began.	R145		
R179 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with	R179		

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R179	Continued From page 4 residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview the RCH Executive Director failed to ensure all staff completed the required 12 hours of training, as evidenced by: During the course of the complaint survey on 5/24/22 the Executive Director was requested to provide proof of completion by direct service staff of the 12 required yearly trainings to include Resident's Rights, Fire Safety, Mandatory Reporting, Infection Control, Emergency Response, Respectful Interactions, and General Supervision. At 2:46 on 5/24/22 the Executive Director confirmed 1 of 5 staff members had not completed any of the 12 hours of required training.	R179	The staff person worked less than six months in 2021 and is currently per diem. This staff will be asked to meet training requirements before working another shift. Executive Director and RN will review all staff training hours and assure 12 hours of required training occurs prior to the end of this year. On-going the DON or Executive Director will quarterly review the status of training hours and assure completion of required trainings.	
R181 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for	R181		

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R181	Continued From page 5 actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Executive Director failed to provide written documentation stating the decision to hire a direct service employee criminally convicted of careless and negligent operation of a vehicle did not pose a threat to residents. Findings include: On 5/24/22 the Executive Director was requested to provide employee criminal background checks for review. The results of criminal background checks revealed 1 of 5 employees was criminally convicted of careless and negligent vehicle operation. At 2:45 PM on 5/24/22 the Executive Director confirmed the employee's personnel file did not contain written evidence the decision to hire the employee did not pose a threat to residents of the Residential Care Home.	R181	The staff member was questioned and history reviewed at time of hire and found that due to the length of time since the conviction and life circumstance changes that they did not pose a threat to residents. Even though this determination was made at time of hire the documentation could not be found in the staff's record. Proper documentation was completed on 6/1/22 and placed in the HR file. All employee files will be reviewed to assure proper documentation is in place by June 30, 2022. The Executive Director will assure all paperwork is complete at time of hire and placed in HR file.	
R206 SS=H	V. RESIDENT CARE AND HOME SERVICES	R206		

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R206	Continued From page 6 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to report 6 incidents of resident to resident physical abuse occurring between 2/26/22 and 4/21/22 to Adult Protective Services (APS) within 48 hours of learning of the abuse. Findings include: Per review of staff notes Resident #1 physically assaulted other residents on 2/26/22, 3/26/22, 4/8/22, 4/18/22 and 4/21/22. On 2/26/22 Resident #1 hit Resident #2 with his/her walker resulting in a cut on Resident #2's right hand and bruising and swelling of his/her fingers. On 3/26/22 Resident #1 grabbed, hit, and scratched Resident #3 resulting in multiple facial abrasions. On 4/8/22 Resident #1 pushed his/her walker into a resident who was trying to exit the dining room as Resident #1 yelled at him/her to leave. On 4/18/22 Resident #1 struck Resident #3 several times before and after staff intervened. On 4/21/22 Resident #1 repeatedly slammed Resident #3's head with a wooden door and pulled his/her hair, then punched Resident #4 as s/he attempted to intervene during this incident. A nursing note dated 5/2/22 at 9:40 AM documented a call placed to APS "to report recent	R206	All resident to resident incidents will be reported to APS within 48 hrs of knowledge of the incident. Annual staff trainings regarding suspected abuse, neglect or exploitation will highlight resident to resident incidents.	

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R206	Continued From page 7 incidents that involved Resident #1 and other residents". On 5/24/22 at 3:18 PM the Executive Director and the Nurse who documented the call to APS on 5/2/22 confirmed the incidents of resident to resident abuse that occurred between 2/26/22 and 4/21/22 were not reported to APS within 48 hours of staff learning of the abuse.	R206		
R208 SS=H	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to report one resident's (Resident #1's) pattern of aggressive behaviors including physical assaults on other residents and staff for a period of 10 weeks from 2/11/22 to 4/21/22 to The Division of Licensing and Protection. Findings include: Per review of staff notes Resident #1 displayed aggressive behaviors during 8 incidents between 2/11/22 and 4/18/22, including 5 assaults on other	R208	First two resident to resident incidents occurred a month apart, next two 10 days apart. The next incident occurred within three days at which time a report was made to Dividion of Licensing and Protection as a significant pattern. Any resident to resident abusive behaviors constituting a pattern of more than two times will be reported to the Division of Licensing and Protection. If there is allegation of abuse, sexual abuse or, injury requiring physician intervention a report will be made as soon as we have knowledge of it. Annual staff trainings will include patterns of resident to resident abuse.	

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R208	Continued From page 8 residents. On 2/11/22 Resident#1 assaulted staff causing bruises, and on 2/26/22 Resident #1 hit Resident #2 with his/her walker resulting in a cut on Resident #2's right hand, bruising and swelling of his/her fingers. On 3/26/22 Resident #1 grabbed, hit, and scratched Resident #3 causing multiple facial abrasions. On 4/8/22 Resident #1 pushed his/her walker into a resident who was trying to exit the dining room as Resident #1 yelled at him/her to leave, and later grabbed staff by the wrists. On 4/18/22 Resident #1 struck Resident #3 several times before and after staff intervened, and later staff intervened as Resident #1 repeatedly attempted to strike another resident. On 4/21/22 Resident #1 pulled Resident #3's hair and repeatedly slammed his/her head with a wooden door while Resident #3 was seated in his/her wheelchair. During this assault Resident #1 punched Resident #4 as s/he attempted to intervene. Resident #3 reported pain on the right side of his/her head and was not transported to the hospital for evaluation. Resident #4 reported feeling "shaken up" and denied physical injury or pain. Resident #1 was transported to the closest hospital for a psychiatric evaluation per Primary Care Provider's orders. On 5/24/22 at 3:24 PM the Executive Director confirmed Resident #1's pattern of aggressive behaviors including physical assaults was not reported to The Division of Licensing and Protection until after the incident on 4/21/22 occurred.	R208		

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R224 SS=H	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to protect the right to be free from mental, verbal and physical abuse for 3 applicable residents. Findings include: Per review of staff notes Resident #1 physically assaulted other residents on 2/26/22, 3/26/22, 4/8/22, 4/18/22 and 4/21/22. On 2/26/22 Resident #1 hit Resident #2 with his/her walker resulting in a cut on Resident #2's right hand and bruising and swelling of his/her fingers. On 3/26/22 Resident #1 grabbed, hit, and scratched Resident #3 resulting in multiple facial abrasions. On 4/8/22 Resident #1 pushed his/her walker into a resident who was trying to exit the dining room as Resident #1 yelled at him/her to leave. On 4/18/22 Resident #1 struck Resident #3 several times before and after staff intervened. On 4/21/22 Resident #1 repeatedly slammed Resident #3's head with a wooden door and pulled his/her hair, then punched Resident #4 as s/he attempted to intervene during this incident. Although the facility staff made efforts to protect each Resident's Rights to be free of abuse by providing increased monitoring of Resident #1 during periods of aggression and making numerous appeals for community supports from	R224	All attempts were and will continue to be made to detect and prevent resident to resident abusive incidents recognizing there are times that are not predictable or that interventions that have been successful all of a sudden no longer work. All attempts were and will continue to be made to place a resident who becomes abusive in a setting that best suits their current needs in order to avoid harm to others, recognizing that the system does not allow for that in a timely and safe manner. Having resources within the state to quickly obtain assistance when a resident's mental status and/or behaviors change and cannot be safely managed in thier current setting is a key aspect to meeting this requirement.	

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R224	Continued From page 10 the local designated agency, hospital, and police in response to Resident #1's assaultive behaviors; Residents #2, #3, and #4 were physically abused by Resident #1. On the afternoon of 5/24/22 the facility Executive Director and Registered Nurse confirmed Residents #1, #2, and #3 were physically assaulted by Resident #1 during periods of mental decompensation resulting in aggressive behaviors. (Refer to R206 and R208)	R224		