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

June 28, 2024

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 **April 24, 2024.** 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.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

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 _____	04/24/2024

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

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R100	Initial Comments: On 4/24/24 the Division of Licensing and Protection conducted an unannounced on-site annual relicensure survey. The following regulatory deficiencies were identified:	R100		
R145 SS=F	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 develop plans of care which describe the care and services necessary to maintain the well-being for 3 out of 3 sampled residents (Residents #1, #2 and #3). Findings include: The facility's Care Plan policy states "The admitting Registered Nurse will complete baseline care plan on admission within 48 hours to address any of the following areas as appropriate ..." and lists appropriate areas including "Pain Management" and " Any other relevant concerns". This policy further states. "The Interdisciplinary team will develop and implement a Comprehensive Care Plan within 30 days of admission assessment date. This comprehensive plan will address resident goals,	R145	All residents will have a comprehensive care plan to include care and services necessary to maintain their well being and current individual needs as some diagnoses in a record may not be a current need. All current care plans will be reviewed and amended to meet the regulations by the Director of Nursing. The Director of Nursing and another RN will review the plans quarterly or when a change is needed.	6/30/2024

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Revision - Kimberly Rabuse Executive Director 6/3/2024

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R145	Continued From page 1 actual and potential problems, needs, strengths and individual preferences of the resident. " 1. Resident #1 is diagnosed with multiple cardiac conditions, and multiple conditions which cause pain including Diabetic Neuropathy, Lumbar Radiculopathy, and chronic Musculoskeletal Pain. Per record review, Resident #1's plan of care does not address his/her risk for a cardiac event and include goals and interventions related to pain management. 2.. Resident #2 is prescribed continuous flow oxygen via nasal cannula and the anticoagulant medication Eliquis. His/her plan of care does not include care instructions and interventions related to use of oxygen via nasal cannula including using water based lubricants and avoiding petroleum based lubricants due to the risk for skin burns, monitoring for skin breakdown and irritation around the ears and nose caused by the nasal cannula and tubing, and safety precautions related to storage and use of oxygen tanks in the resident's room. Per record review, Resident #2's plan of care does not include instructions and interventions related to the risk for bleeding associated with the use of anticoagulant medication, including instructions for staff regarding signs of internal bleeding and when to seek medical help for uncontrolled or persistent bleeding. 3. Resident #3 is diagnosed with multiple cardiac conditions and is prescribed the anticoagulant medication Eliquis. per record review, Resident #3's plan of care does not address his/her risk for a cardiovascular event, and does not include instructions and interventions related to risk for bleeding associated with the use of anticoagulant medication.	R145	R145 Plan of Correction accepted by Jo A Evans RN on 6/28/24	

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R145	Continued From page 2 On the afternoon of 4/24/24 the Registered Nurse acknowledged the plans of care for 3 out of 3 sampled residents did not include care and services necessary to maintain the residents well-being. In conclusion this deficient practice is a risk for more than minimal harm to all residents resulting from unidentified residents needs and interventions.	R145		
R147 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.9.c (4) Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure medication orders for 3 out of 3 sampled residents included the dose and frequency of administration. Findings include: The facility's PRN Medications policy states, "Clear and precise written directions must be obtained from the Doctor" and lists what the Doctor's orders must cover including, "Indication for the use of medication. Circumstances under which a further dose can be administered and what is considered a safe interval between doses.	R147	The DON will work with physicians offices to include initial indication, second dose indication,safe interval between doses and when applicable the maximum dosage per day and parameters to be met especially for these residents that have been deemed safe to self administer medications and keep them in their rooms. Upon receipt of orders RN will review for any missing components and address that with prescriber . MARS will continue to be reviewed monthly and look for any missing elements by the RN. All current MARS will be reviewed and amended to meet these expectations by the DON.	6/21/2024

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R147	Continued From page 3 The maximum PRN dose per day if applicable. Parameters to be met if applicable." Per record review of the April 2024 Medication Administration Records (MARs) for a sample of 3 resident, the MARs for 3 out of the 3 residents sampled included orders for PRN medications without specific doses and/or frequency of administration to include the amount of time between doses as follows: 1. Resident #1's MAR included: a. "APAP [Tylenol] 500 mg tabs 1-2 tablets by mouth up to three times daily". This order does not include a specific dose and frequency of administration; and dose not include the indications for use. b. "Benzonatate Cap 100 mg Give 1 or 2 caps per dose, by mouth as needed for cough". This order does not include a specific dose and frequency of administration. c."Hydrocort Cre 1% Apply topically to affected area twice daily as needed for bug bites". This order does not include a specific dose and frequency of administration. d. "Ocusoft Lid Scrub Use as directed daily as needed". This order does not include a specific dose and frequency of administration; and dose not include the indications for use. e. "Artificial Tears (Systane or Refresh) Instill one drop in ea. eye up to 4 x day". This order does not include a specific frequency of administration; and dose not include the indications for use. f. "Systane Ultra 0.3-0.4 % Instill One drop in each eye up to four times daily". This order does not include a frequency of administration; and dose not include the indications for use. Additionally this order is a duplication of the previous order listed which is a risk for overdose.	R147	R147 Plan of Correction accepted by Jo A Evans RN on 6/28/24	

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R147	Continued From page 4 2. Resident #2's MAR included: a. "Lorazepam Tab 0.5 mg Take 1 tablet sublingually every 2-6 hours as needed for anxiety/agitation". This order does not include a specific frequency of administration. b. "Refresh Tears 0.5% Drop Instill 1 drop in each eye as needed". This order does not include a specific frequency of administration. c. "Vicks Vaporub Ointment Apply a small amount four times daily as needed as directed". This order does not include a specific frequency of administration and indication for use. d. "APAP [Tylenol] 500 mg tabs 1-2 tablets by mouth every 4-6 hours as needed". This order does not include a specific dose and frequency of administration; and dose not include the indications for use. e. "Bacitracin Ointment Tube Use as directed". This order does not include a specific dose and frequency of administration; and dose not include the indications for use. f. "Bengay Cre Ultra St Apply to painful affected area three times daily as needed". This order does not include a specific dose and frequency of administration. g. "Diclofenac Gel 1% Apply topically to painful areas four times daily as needed ". This order does not include a specific dose and frequency of administration. 3. Resident #3's MAR included: a. ""APAP [Tylenol] 500 mg tabs 1-2 tablets by mouth up to three times daily as needed for Fever/Pain/Discomfort". This order does not include a frequency of administration. b. "Bacitracin Ointment Tube Apply topically up to twice daily as needed for abrasions or skin tear". This order does not include a specific dose and frequency of administration.	R147		

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R147	Continued From page 5 c. "Diclofenac Gel 1% Apply topically to right elbow four times daily as needed for pain". This order does not include a specific dose and frequency of administration. d. "Loperamide tab 2 mg Take 1-2 tablets by mouth every 2 hours as needed for diarrhea". This order does not include a specific dose. e. "Nystatin Cream Apply to affected area four times daily as needed for red rash/fungal areas". This order does not include a specific dose and frequency of administration. On the afternoon of 4/24/24 the Registered Nurse confirmed PRN medication orders for 3 out of 3 sampled residents (Residents #1, #2, and #3) did not include a specific dose and frequency of administration including the amount of time between doses. In conclusion this deficient practice is a risk for more than minimal harm for all residents due to administration of PRN medications at an incorrect dose and/or frequency to address the symptoms the medication is intended to treat, and the failure to ensure the information listed on the MAR conveys instructions for administration as the prescriber intended.	R147		
R175 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (3) Residents who are capable of self-administration may choose to store their own medications provided that the home is able to provide the resident with a secure storage space to prevent	R175		

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R175	Continued From page 6 unauthorized access to the resident's medications. Whether or not the home is able to provide such a secured space must be explained to the resident on or before admission. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview medications stored in the room of one applicable resident (Resident #1) who self-administers medications were not stored in a secured storage space to prevent unauthorized access. Findings include: The facility's Medication Storage policy provided for review on 4/24/24 does not address storage of self-administered medications in a secure storage space, and only includes policies related to storage of medications staff manages. A letter from the Director of Nursing provided to residents who are approved to self administer medications identifies the facility's policies for self administration of medications, however this letter does not include the requirement to store medications in a secured storage space. During a tour of resident rooms commencing at 12:32 PM on 4/24/24 unsecured medications were observed in Resident #1's room including Tylenol 500 mg tablets, Vitamin C 500 mg tablets, Refresh Tears Eye Drops, Hydrocortisone Cream, and Antibiotic Ointment. This finding was confirmed by the Executive Director during the tour of resident rooms on 4/24/24. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents resulting from access to medications by residents incapable of safely self administering medications, and by other individuals who are not	R175	Any resident approved to self administer medications will be given a lock box in their room. This will be overseen by the Executive Director. The medication storage policy will be amended to include storage of medication in a residents room by the Director of Nursing. R175 Plan of Correction accepted by Jo A Evans RN on 6/28/24.	6/19/2024 7/3/2024

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R175	Continued From page 7 authorized to have access to resident medications.	R175		
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to develop policies and procedures that govern all services provided by the home. Findings include: During the survey conducted on 4/24/24 the Executive Director was requested to provide facility policies and procedures related to storage of hazardous chemicals, maintenance of fire extinguishers, and fire drills. On the afternoon of 4/24/24 the Executive Director confirmed the policies and procedures listed above had not been developed. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to failure to provide accessible information and clear instructions related to tasks staff are required to perform.	R200	A policy exists related to hazardous chemicals just not related to storage of cleaning supplies purchased by residents in their rooms. The Administrative office will amend the policy and procedures to include proper handling of cleaning products or other chemicals purchased by residents. The Administrative Office will develop a policy related to the maintenance of fire extinguishers. A fire drill procedure exists in the fire policy which states a drill will occur every shift. The Administrative Office will amend the policy to match the wording in the regulations.	7/3/2024
R247 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation	R247	Staff will be educated as to where all policies and procedure manuals are via communication logs and/or staff meetings.	7/3/2024

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R247	Continued From page 8 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all perishable beverages are stored and served at or below 40 degrees Fahrenheit. Findings include: The facility's Purchasing, Receiving, and Storage policy states, "Food will be properly stored to preserve flavor, nutritive value, appearance, and safety."; and includes a procedure which states, "All perishable foods will be stored at proper temperature: refrigerated at 40 degrees or below...". On the afternoon of 4/24/24 the beverages in the kitchen drink dispenser were observed to be stored and dispensed at temperatures above 40 degrees Fahrenheit. The temperature of the cranberry beverage was 46.2 degrees and the orange juice was 46.8 degrees Fahrenheit. This finding was confirmed by the Executive Director at 1:10 PM on 4/24/24. In conclusion, this deficient practice is a potential risk for more than minimal harm due to food borne illness for all facility residents.	R247	R200 Plan of Correction accepted by Jo A Evans RN on 6/28/24. This has already been corrected as the company that services the machine has been here and the temperature in the machine continues to register between 36-38 degrees. The kitchen manager will get a thermometer to place in the juice machine and the kitchen staff will do a daily temperature log. This will be overseen by the kitchen manager. R247 Plan of Correction accepted by Jo A Evans RN on 6/28/24	6/10/2024
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment	R266		

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R266	Continued From page 9 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to provide care in a safe environment related to storage of chemicals; emergency preparedness and fire safety; and the storage and use of oxygen tanks. Findings include: The facility's Resident Quality of Life Policy identifies the facility's focus is to "Maintain a safe physical environment for EVERY resident to support resident well-being and quality of life" and to "Ensure the building design, room layouts, configurations, and indoor/outdoor spaces are safe ..." On the afternoon of 4/24/24 the following environmental safety issues were observed: 1. Unsecured hazardous chemicals and cleaning products were observed in Resident #1's room including Miracle Grow fertilizer, Lysol spray, and Febreeze spray. This finding was confirmed by the Executive Director at approximately 1:00 PM on 4/24/24. On the afternoon of 4/24/24 the Executive Director was requested to provide copies of facility policies and procedures related to storage of chemicals in resident rooms for review. Policies and procedures related to this area of service were not on file and available for review; however the Surveyor was provided a Room	R266	Many residents have the independence to shop and care for their own room to their liking therefore we perform biannually room checks to assure resident safety. In order to allow continued resident choice and fulfillment of caring for their own things the DON will educate residents of the regulations and offer to keep any unsafe products in a storage bin in our locked storage closet. Staff will be educated to scan residents rooms when in there for any hazardous materials and report it to the RN. The Administrative Office will amend the hazardous chemicals policy to include resident rooms. R266 Plan of Correction accepted by Jo A Evans RN on 6/28/24	6/14/2024 7/3/2024

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R266	Continued From page 10 Check Completion document which includes a section entitled Toxins that asks, "Are there any cleaning supplies in the room?" and "Are there any times that present danger to the resident/toxicity/potentially harmful?". 2. The fire extinguishers throughout the home were observed with outdated inspection stickers indicating the extinguishers were due to be inspected in February of 2024. This finding was confirmed by the Executive Director at 1:05 PM on 4/24/24. On the afternoon of 4/24/24 the Executive Director was requested to provide the facility's policies and procedures for inspecting and maintaining facility fire extinguishers for review. The Executive Director confirmed facility policies and procedures related to inspecting and maintaining fire extinguishers had not been developed by the home. 3. In Resident #2's room 2 oxygen tanks were observed to be stored against the radiator. Four oxygen tanks were observed to be stored within approximately 1-2 feet of the radiator, including one which was attached to the resident's oxygen compressor unit. Two of the tanks were stored within inches of the resident's television. This finding was confirmed by the Executive Director and Registered Nurse at approximately 12:45 PM on 4/24/24. On the afternoon of 4/24/24 the facility's policies and procedures for storage and use of oxygen were requested for review. In response, the Registered Nurse provided a document entitled Precautions and Safe Practices Medical Oxygen Systems in the Home which states, "Electrical equipment which gets hot can be a source of	R266	#2 we are actually in compliance as the tag on the extinguishers was read incorrectly and we are not due for an inspection until the end of July 2024. This was confirmed by D&M Fire Safety. A procedure for inspecting of fire extinguishers will be added to our current fire policy by the Administrative office. All oxygen and tanks were immediately relocated at least 10 feet away from the heaters and television set. The DON will oversee placement of oxygen equipment by the company as it occurs.	7/3/2024 completed as needed

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R266	Continued From page 11 ignition. Keep radios, television sets and heaters, and electric razors at least 10 feet away from oxygen units... Do not locate or store any oxygen container near radiators, heat ducts, steam pipes or other sources of heat." In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to potential access and exposure to poisonous compounds, risk for fire and injuries associated with improper storage and use of oxygen , and the failure to ensure the facility's fire extinguishers are properly maintained and ready for use should a fire occur.	R266	R266 Plan of Correction accepted by Jo A Evans RN on 6/28/24	
R302 SS=F	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to conduct fire drills at least once	R302		

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 _____	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRAFTSBURY COMMUNITY CARE CENTER, INC.	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
R302	Continued From page 12 yearly in the evening and night. Findings include: On the morning of 4/24/24 the Executive Director was requested to provide the facility's policies and procedures for conducting fire drills for review. The facility's Fire Evacuation Plan was provided, however this plan does not include policies and procedures for conducting fire drills at the facility. On the morning of 4/24/24 the Executive Director was requested to provide documentation of fire drills completed by the home during the previous year for review. Per review of the documentation provided, fire drills were not conducted during the evening and night during the previous year. This finding was confirmed by the Executive Director at 12:09 PM on 4/24/24. This deficient practice is a potential risk for more than minimal harm for all facility residents due to missed opportunities for staff and residents to practice the evacuation process, and identify effective procedures for safe and timely evacuation.	R302	A fire drill procedure exists in the fire policy which states a drill will occur every shift. The Administrative Office will amend the policy to match the wording in the regulations. Staff will be educated as to location of this policy via communication logs and/or staff meeting. A minimum of 4 fire drills will occur annually with one being in the morning, one in the afternoon, one in the evening and one at night. This will be overseen by the DON and Administrative Office. R302 Plan of Correction accepted by Jo A Evans RN on 6/28/24	7/3/2024 7/3/2024 Annually by March 31, June 30, September 30, and December 30.