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

November 17, 2023

Ms. Holly Blair
Pine Knoll Community Care Home
601 Red Village Road
Lyndonville, VT 05851

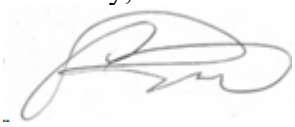
Dear Ms. Blair:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 17, 2023.** 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
	0171	A. BUILDING: _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL COMMUNITY CARE HOME	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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: On 10/17/23 the Division of Licensing and Protection conducted on unannounced on-site relicensure survey and investigation of one complaint. There were no regulatory deficiencies identified related to the complaint investigation. The following regulatory deficiencies were identified during the re-licensure survey:	R100	R134 1. No negative outcomes occurred as a result of this alleged deficient practice. 2. Residents being admitted into the facility have the potential to be affected by the alleged deficient practice. 3. An audit was completed to ensure no other residents' assessment has not been completed within 14 days. 4. Education provided to RN completing resident assessment to ensure the assessment will be completed within 14 days of admission. 5. Residential care manager or designee will conduct weekly audits to monitor effectiveness of the plan. 6. Results of the audit will be reported to the administrator Monthly. Corrective action will be completed by November 10, 2023. R134 Plan of Correction accepted by Jo A Evans RN on 11/17/23	
R134 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Registered Nurse failed to complete an admission assessment for one applicable resident (Resident #1) within 14 days of admission. Findings Include: Per record review Resident #1 was admitted to the home on 8/26/20, and his/her admission Resident Assessment form was signed as complete by the Registered Nurse on 10/12/20. On the afternoon of 10/17/23 the Manager of the home confirmed an assessment was not completed for Resident #1 within 14 days of admission.	R134		

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R145	Continued From page 1	R145	R145	
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 develop a written plan of care to address the care and services required to maintain the well-being of two applicable residents (Residents #1 and #2). Findings include: 1. Per record review Resident #1 has diagnoses including Diabetes Mellitus, cardiovascular conditions, a blood disorder that interferes with blood clotting, and a history of deep vein thrombosis (blood clot). Resident #1's plan of care does not address care and services required related to Diabetes, risk for a cardiac event, and risks for excessive bleeding and clotting. 2. Per record review Resident #2 has diagnoses including Atrial Fibrillation (irregular heartbeat increasing the rick of blood clotting and stroke), Prediabetes, and General Anxiety Disorder. S/he has a history of repeat falls. Resident #2's Plan of Care does not include care and services required related to the use of anticoagulant	R145	1. No negative outcomes occurred as a result of this alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. Resident #1 and #2 care plans have been appropriately updated to reflect their diagnosis and treatments. 4. An audit was completed to ensure all other residents' care plans reflect their diagnosis and treatment. 5. Education was provided to staff completing care plans to ensure the proper diagnosis and treatment will be care planned. 6. Residential care manager or designee will conduct weekly audits to monitor effectiveness of the plan. 7. Results of the audit will be reported to the administrator Monthly. Corrective action will be completed by November 10, 2023. R145 Plan of Correction Accepted by Jo A Evans RN on 11/17/23	

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R145	Continued From page 2 medication, prevention and management of anxiety, interventions for prediabetes to reduce the risk of Diabetes, and risk for falls. On the afternoon of 10/17/23 the Manager acknowledged the written plans of care on file did not include care and services to meet Resident #1 and #2's needs.	R145	R179 1. No negative outcomes occurred as a result of this alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. Residential manager is aware of the requirement of 12 hours of training per year. 4. The number of hours missing for in-service education will be completed for all effective staff members. 5. Residential care manager or designee will conduct weekly audits to monitor effectiveness of the plan. 6. Results of the audit will be reported to the administrator Monthly. Corrective action will be completed by November 10, 2023. R179 Plan of Correction accepted by Jo A Evans RN 11/17//23	
R179 SS=F	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 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.	R179		

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R179	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review 5 out of 5 sampled staff did not complete the required yearly trainings. Findings include: Per review of documentation of staff traiings completed 5 ouf of 5 sampled staff did not complete the required yealry resident emergency response procedures to include first aid training. This finding was confirmed by the Manager of the home at approximatley 1: 50 PM on 10/17/23.	R179	R190 1. No negative outcomes occurred as a result of this alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. Residential manager is aware of the requirement to complete criminal record and adult abuse registry. 4. An audit was completed on all other staff employed at the facility. There were no other employees without completed background checks. 5. Residential manger was educated to ensure criminal background checks are completed prior to employment. 6. Residential care manager or designee will conduct monthly audits to monitor effectiveness of the plan. 7. Results of the audit will be reported to the administrator Monthly. Corrective action will be completed by November 10, 2023.	
R190 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the required abuse registry checks were not on file and available for review for 1 out of 5 sampled staff. Findings include: Based on record review adult and child abuse registry checks completed on hire for 1 out of 5 sampled staff were not on file and available for review on request. This finding was confirmed by the Manager of the home at 4:20 PM on 10/17/23.	R190		
R247 SS=F	VII. NUTRITION AND FOOD SERVICES	R247		

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R247	Continued From page 4 7.2 Food Safety and Sanitation 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, staff interview, and record review there was a failure to ensure perishable beverages are held at or below 40 degrees Fahrenheit and perishable food items are served at or above 140 degrees Fahrenheit during meal service. Findings include: 1. During the lunch meal service on 10/17/ 23 all beverages served to residents were observed to be held above 40 degrees Fahrenheit. The temperatures of beverages served during lunch service were grape juice 52.2 degrees Fahrenheit, pineapple Juice 49.3 degrees Fahrenheit, orange juice 43.4 degrees Fahrenheit, soda 52.2 degrees Fahrenheit and milk 52.3 degrees Fahrenheit. Additionally the water served at lunch was observed to be 55.8 degrees Fahrenheit. 2. Per review of documentation of routine temperature testing of the last tray served during meal times 25 out of 30 sampled meal tray temperatures between 10/3/23 and 10/16/ 23 were above 140 degrees Fahrenheit. The 25 recorded meal tray temperatures documented above 140 degrees ranged from 100 to 138 degrees. On the afternoon of 10/17/23 the Manager of the	R247	R190 Plan of Correction accepted by Jo A Evans RN on 11/17/23 R247 1. No negative outcomes occurred as a result of this alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. Staff have been educated to place all perishable beverages on ice or in the refrigerator prior to serving. 4. Staff have been educated to close the door to the serving cart while serving trays. 5. Residential care manager or designee will conduct weekly audits to monitor effectiveness of the plan. 6. Results of the audit will be reported to the administrator Monthly. Corrective action will be completed by November 10, 2023. R247 Plan of Correction accepted by Jo A Evans RN on 11/17//23	

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R247	Continued From page 5 home confirmed the lunch service beverages temperatures were above 40 degrees Fahrenheit and documentation of meal tray temperatures taken between 10/3/23 and 10/16 23 indicated 25 out of 30 meal trays were above 140 degrees Fahrenheit.	R247	R266 1. No negative outcomes occurred as a result of this alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. Residential manager is aware of the requirement to keep hazardous chemicals in a locked area. 4. The cabinet with hazardous chemical has had a lock installed and the key will be kept with the medication keys. 5. The door to the storage closet had a keypad lock installed to ensure residents are not able to access the closet. 6. Residential care manager or designee will conduct audits 3x a week monitor effectiveness of the plan. 7. Results of the audit will be reported to the administrator Monthly. Corrective action will be completed by November 10, 2023.	
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 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 ensure care in a safe environment. Findings include: 1. At approximately 10:15 AM on 10/17/23 a strong smell of bleach was observed in the hallway of the home. At the end of the hallway a cleaning closet was observed with the door left open and with no staff present in the area.. A cleaning cart with cleaning products on top was stored in the closet. Large containers of bleach and other cleaning products were observed to be accessible on the closet floor including one container which was open and without a cap. An unlocked cupboard in the closet contained Comet disinfecting powder and a disinfectant spray. At 10:20 AM on 10/17/23 Staff on duty confirmed the closet was open leaving unsecured hazardous chemicals accessible to residents. Staff also confirmed the door of the cleaning closet is	R266		

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R266	Continued From page 6 customarily left unlocked. The Case Manager acknowledged hazardous cleaning products were accessible to residents in the unlocked cleaning closet at 10:53 AM on 10/17/23. On recheck at 11:37 AM the door was now closed but remained unlocked with chemicals still unsecured and accessible. 2. During the facility environmental tour commencing at 11:08 AM on 10/17/23 cleaning chemicals were observed to be unsecured and stored in resident rooms including Lysol disinfectant spray and bleach wipes. 3. At 11:37 AM on 10/17/23 the boiler room of the home was observed to be left unlocked; leaving the boiler, a cart of personal protective equipment, and incontinence supplies stored in the room accessible to residents. 4. At 11:45 AM the Salon was observed to be unlocked and open with disinfectant spray on the counter and deodorizer in an unlocked cabinet. The Salon also serves as the shower room for facility residents Salon , and was observed to be without non skid surfaces or mats placed on the flooring to prevent slips and falls. These findings were confirmed by the Manager of the home at 12:05 PM on 10/17/23.	R266	R266 Plan of Correction accepted by Jo A Evans RN on 11/17/23	