VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
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AGENCY OF HUMAN SERVICES

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

December 29, 2025

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 **December 8, 2025.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

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 _____	C 12/08/2025

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

R206, R224, R232, R372, and R381
Accepted 12-29-25
Susan Canas Gregoire RN

(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 December 8, 2025, the Division of Licensing and Protection conducted an unannounced on-site annual survey, along with an investigation of one facility reported incident. The following regulatory deficiencies were identified pertaining to both the relicensure survey and the facility reported incident investigation:	R100		
R206 SS=F	5.10.h (4) Medication Management Medications left after the death or discharge of a resident, or outdated medications, must be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the home failed to ensure the prompt disposal of outdated medications, which were observed to be retained and available for use. Findings include: The home's Medication Disposal Policy states that medications remaining after the death or discharge of a resident shall be returned to the pharmacy for refund when applicable, and that all narcotics and non-refundable medications will be disposed of within one week of the resident's death or discharge. However, the policy does not address the disposal of medications for which the prescriber's order has been changed or discontinued. During an inspection of the medication closet storage area of the home conducted on the	R206	Deficiency Statement Plan of Correction Template used.	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kimberly Roberge TITLE Executive Director (X6) DATE 12/23/25

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R206	Continued From page 1 morning of December 8, 2025, medications were observed stored without a current written order, including 19 Atorvastatin 40 MG tablets labeled "not active," 30 Levothyroxine 75 MCG tablets, and 4 SMZ/TMP DS Antibiotic tablets. Per interview with the Registered Nurse on the morning of December 8, 2025, the Registered Nurse stated that medications were sometimes left in the closet in case the dosage or medication was ordered again by the provider. However, standard nursing practice requires that medications without a current written provider order be removed from the home or disposed of appropriately. The Registered Nurse and the Manager confirmed these findings on the morning of December 8, 2025.	R206		
R224 SS=D	5.12.b (3) Records/Reports The home must keep and maintain the following records: For residents requiring nursing care, including nursing overview or medication management, the record must also contain: initial assessment; annual reassessment; significant change assessment; licensed health care provider ' s admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of licensed health care provider visits, signed telephone or electronic orders and treatment documentation; and resident plan of care. This REQUIREMENT is not met as evidenced	R224		

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R224	Continued From page 2	R224		

by:
Based on staff interviews and record review, the home failed to ensure that the resident record for Resident #1 included all required documentation. Findings include:

The Home Accident and Incident Report Policy state that the home's practice is to ensure incidents are documented including required notifications, treatment provided and relevant comments, within the nurse's notes. The home's Care Plan Policy states that the resident's care plan shall be individualized, interdisciplinary and on-going, and that the care plan will be reviewed and revised in response to any significant change in the resident's condition.

Per record review of the home's Incident Summary on the afternoon of December 8, 2025, documentation indicated that Resident #1 reported missing money from their room on November 2, 2025. The documentation stated that the money had been withdrawn from a savings account in late October 2025 for the purpose of treating friends to lunch on a birthday. The Incident Summary noted that the reported missing amount ranged between $300 and $2,000 depending on various reports as of November 25, 2025. Further documentation reflected that it is believed $1355 had been withdrawn, with $100 accounted for leaving $1255 unaccounted for. The incident further documented that Resident #1 believed the money had been stolen and reported storing the money in a wallet inside a purse and was adamant that the money had not been placed elsewhere.

Resident #1 reported that the money consisted of $100 and $20 bills and stated that the money would not have been stored in any location other

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R224	Continued From page 3	R224		

than the purse. Resident #1 further stated that the funds were withdrawn in late October 2025 in connection with a birthday occurring in early November and confirmed the money has been missing and has not been recovered since early November 2025. Resident #1 reported feeling distressed that the money had not been recovered and stated that the purse was no longer left unattended in the room due to concerns about further loss of property.

Per record review on the afternoon of December 8, 2025, Resident #1's progress notes did not include any information about the reported missing money, Resident #1's response to the incident or the facility's response to Resident #1 in the investigation or support given. Additional record review of Resident #1's plan of care indicated the plan had not been updated to include any support for behaviors or management of resident's feelings of not trusting the facility.

Per interview with the Medication Technician on the morning of December 8, 2025, the Medication Technician reported that after Resident #1 discovered that money withdrawn from the bank was not in their purse the Resident entered the common dining area where multiple residents were present and stated that their money had been stolen and appeared concerned.

Per record review on the afternoon of December 8, 2025, Resident #1's progress notes did not include documentation of the reported missing money, the Resident's response, or any follow-up actions taken by the home. Additional record review of Resident #1's plan of care indicated that the plan had not been updated to reflect interventions related to the incident.

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R224	Continued From page 4 These findings were confirmed by the Manager on the afternoon of December 8, 2025.	R224		
R232 SS=D	5.12.c (5) Records/Reports Any reports, allegations, or incidents of abuse, neglect, exploitation of residents or misappropriation of resident property must be reported to the licensing agency. i. The licensee and staff must report any case of suspected abuse, neglect or exploitation of a resident to Adult Protective Services (APS). A separate report must also be made to the licensing agency. APS may be contacted by calling toll-free 1-800-564-1612. The licensing agency may be contacted by calling toll-free 1-888-700-5330. The home must make the reports to APS and to the licensing agency immediately but not later than within 48 hours of learning of the suspected, reported or alleged incident. ii. In addition to filing the reports as described above, a home must conduct its own investigation and must take immediate steps to prevent further abuse, neglect or exploitation from occurring. The results of the home ' s investigation must be reported to the licensing agency within 5 business days from the date of the initial report of the allegation. The home's investigation and determination must not delay reporting of the alleged or suspected incident to Adult Protective Services and to the licensing agency. iii. Incidents involving resident-to-resident abuse must be reported to the licensing agency any time a resident alleges, or the licensee or staff	R232		

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R232	Continued From page 5 observe or suspect, verbal, physical or mental abuse; sexual abuse, if an injury has resulted; or if there is a pattern of abusive behavior. (A) All resident-to-resident incidents, even minor ones, must be recorded in the resident ' s record. (B) The home must notify legal representatives and families (if permitted) about the incident(s) and must document the report and the plan the home developed to address the behaviors. the following reports with the licensing agency: This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and record review, the home failed to ensure that an allegation of potential exploitation and/or misappropriation of a resident's property was reported to Adult Protective Services and the Licensing Agency within the required 48-hour timeframe following discovery of the alleged incident. Findings include: The homes policy for reporting incidents aligns with the licensing rules. Per record review of the home's Incident Summary on the afternoon of December 8, 2025, documentation indicated that Resident #1 reported missing money from their room on November 2, 2025. The documentation stated that the money had been withdrawn from a savings account in late October 2025 for the purpose of treating friends to lunch on a birthday. The Incident Summary noted that the reported missing amount ranged between $300 and $2,000 depending on various reports as of November 25, 2025. Further documentation reflected that it is believed $1355 had been	R232		

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R232	Continued From page 6 withdrawn, with $100 accounted for leaving $1255 unaccounted for. The incident further documented that Resident #1 believed the money had been stolen and reported storing the money in a wallet inside a purse and was adamant that the money had not been placed elsewhere. Continued record review of the home's Incident Summary revealed that the incident was discovered on November 2, 2025; however, the initial report to Adult Protective Services did not occur until November 18, 2025, and the initial report to the Division of Licensing and Protection did not occur until November 20, 2025. Resident #1 reported that the money consisted of $100 and $20 bills and stated that the money would not have been stored in any location other than the purse. Resident #1 further stated that the funds were withdrawn in late October 2025 in connection with a birthday occurring in early November and confirmed the money has been missing and has not been recovered since early November 2025. During an interview on the afternoon of December 8, 2025, the Manager confirmed that the incident was not reported to Adult Protective Services or the Licensing Agency within the required 48-hour timeframe following discovery of the alleged incident.	R232		
R372 SS=F	7.1.a (4) Menus and Nutritional Standards The current week's regular and therapeutic menu must be posted in a public place for residents and other interested parties. This REQUIREMENT is not met as evidenced	R372		

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R372	Continued From page 7 by: Based on observation and staff interview, the home failed to ensure that a weekly menu was posted in a public location accessible to residents and other interested parties, as required by State Rules. Findings include: The home's Menus and Nutritional Standards Policy states that the current week's regular and therapeutic menu shall be posted in a public place for residents and other interested parties. Per observation, during a tour of the home conducted on the morning of December 8, 2025, no weekly menu was observed posted in any common or publicly accessible area of the home. Per a staff interview, conducted with the Manager on the afternoon of December 8, 2025, the Manager confirmed that there was no weekly menu posted at that time and stated that it was their intention to begin posting one in a common area.	R372		
R381 SS=F	7.2.a Food Safety and Sanitation Each home must procure food from sources that comply with all laws relating to food and food labeling. The home must ensure that all food is safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks must be rejected and kept separate until returned to the supplier. This STANDARD is not met as evidenced by: Based on observation and staff interview, the	R381		

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R381	Continued From page 8 home failed to ensure dented cans were rejected upon receipt and maintained separately from usable food items until returned to the supplier. Findings include: The home's policies and procedures governing dented cans are consistent with the licensing rules for Residential Care Homes. Per observation, during a tour of the home's kitchen and food storage areas on the morning of December 8, 2025, a can of Campbell's Cream of Mushroom Soup, three 12-ounce cans of Albacore Tuna and Mandarin Oranges in light syrup were observed to be stored on the same rack as food items intended for resident consumption. Per interview, this finding was confirmed by the Manager after reviewing photographs of the dented cans on the afternoon of December 8, 2025.	R381		

Deficiency Statement Plan of Correction (POC)

Survey Date: December 8, 2025

Facility Name: Craftsbury Community Care Center

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R206	On 12/9/25, Atorvastatin, Levothyroxine, and Antibiotics identified in the Statement of Deficiencies were disposed of.	On 12/9/25, all current resident medications were reviewed, and then the Director of Nursing purged the medication closet of all discontinued medications and subsequently disposed of them.	12/9/25	On 12/9/25, the Director of Nursing updated the Medication Disposal Policy to include the disposal of medications for which the prescriber's order has been changed or discontinued. Staff was educated on the policy change. R206 Accepted 12-29-25 Susan Canas Gregoire RN	Director of Nursing
R224	Director of Nursing has supplemented the APS report in Resident #1's nursing notes and added thorough supplemental notes to include the resident's response to the incident and the facility's follow up actions, including facility's attempts of counseling. Resident #1's plan of care was also amended to include supporting resident with feelings following the incident.	Recent incident and accident report documentation was reviewed which confirmed that no other residents' progress notes or plans of care were missing information related to incidents.	2/1/26	Accident and Incident Report policy and process will be reviewed and nursing staff will be educated on the requirement to include the situation, resident response, and actions taken by the facility for any future incidents. Where applicable, the plans of care will also be amended to reflect support offered to residents related to incidents. R224 Accepted 12-29-25 Susan Canas Gregoire RN	Director of Nursing and Executive Director
R232	We cannot retroactively report this incident within 48 hours. We	We are not aware of any incidents related to other	2/1/26	We will educate staff at our February staff meeting as to appropriate process for reporting	Director of Nursing and

	have gotten clarification from DLP to inform our response in the future. R232 Accepted 12-29-25 Susan Canas Gregoire RN	residents requiring reporting at this time.		within 48 hours, not to be delayed by our investigation. When there is a credible report of neglect, abuse, or exploitation, it will immediately be escalated to the director of nursing or administrative team to make a report within 48hours prior to any internal investigations.	management team
R372 R372 Accepted 12-29-25 Susan Canas Gregoire RN	The current weekly menu has been temporarily posted on the counter at the Nurse's station for all residents to view.	Maintenance has been instructed to install a bulletin board in the common area near resident mailboxes, where the weekly menu will be posted for all residents to see.	12/31/25	Each week, by Saturday evening at the latest, the Dietary Manager will deliver the upcoming week's menu (Sunday to Saturday) to the Delegated Med Tech on duty to be posted on the new resident bulletin board following the final meal on Saturday.	Assistant Operations Manager will monitor weekly to ensure compliance.
R381	Current stock was thoroughly examined on 12/9/25, and any dented cans were removed from the storage area intended for resident consumption. R381 Accepted 12-29-25 Susan Canas Gregoire RN	Current stock was thoroughly examined on 12/9/25, and any dented cans were removed from the storage area intended for resident consumption.	1/20/25	When unpacking the food order, the cook will look for any dented cans, at which time they will place them in a designated box labeled 'Not for resident consumption- Return to food vendor'. They will notify the food vendor of the rejected cans and arrange removal from the property. All kitchen staff will be educated at the January 2026 kitchen meeting to be aware of this process.	Dietary Manager will periodically scan food storage area to ensure compliance.