VERMONT

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

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Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 25, 2025

Alycia Hodgman, Manager
Vernon Assisted Living Residence
13 Greenway Drive
Vernon, VT 05354

Dear Ms. Hodgman:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 4, 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
	1006	A. BUILDING: _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON ASSISTED LIVING RESIDENCE	13 GREENWAY DRIVE VERNON, VT 05354

(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 relicensure survey was conducted by the Division of Licensing and Protection on June 4, 2025. The following regulatory violations were identified.	R100		
R213 SS=F	5.11.e (2) Staff Services The licensee must take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references, contacting the Division of Licensing and Protection, the Department for Children and Families and the Department of Public Safety's Vermont Criminal Information Center (VCIC) or another national background check vendor to see if prospective employees are on the Vermont abuse registries or have a record of convictions in any state or territory. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the Assisted Living Facility (ALR) failed to ensure to obtain annual criminal background checks for 5 out of 5 sampled staff. Findings include: On June 4, 2025 the Manager confirmed policies and procedures related to completion of staff criminal background and abuse registry checks were not on file and available to review. Per record review, the facility failed to obtain the required Vermont Criminal Conviction Information (VCIC) background checks for 5 out of 5 sampled staff. Per interview conducted on June 4, 2025, the Manager confirmed that the annual background	R213		

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R213	Continued From page 1 checks had not been completed per state licensing rules.	R213		
R342 SS=F	5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy must be available at the home for review upon request by residents and their representatives, advocacy organizations and the licensing agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure of the Assisted Living Facility (ALR) to develop, and maintain on file and available for review, policies and procedures governing all services provided by the home. Findings include: During the course of the annual survey conducted on June 4, 2025, the Facility Manager, Director of Nursing and the Kitchen Manager were requested to provide written policies and procedures addressing staff criminal record and abuse registry checks; medication administration training and delegation; staffing levels; environmental cleaning schedules; maintenence logs verifying equipment cleanliness and functionality; and menu planning and meal service. During the afternoon of June 4, 2025 the Facility Manager and Director of Nursing confirmed the requested policies listed above had not been developed by the home.	R342		

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R373	Continued From page 2	R373		
R373 SS=F	7.1.a.(5) Menus and Nutritional Standards The home must follow the written, posted menus. If a substitution must be made, the substitution must be recorded on the written menu. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and record review, the home failed to adhere to the posted meal menus as required by state rules. Findings include: On June 4, 2025, the Food Service Director confirmed policies and procedures relating to meal menus had not been developed in the home. Per the home's Assisted Living Resident Handbook, that each resident receives upon admission, it states that menu selection, food preparation and food purchasing is managed by the Food Service Director. Per observation at 12:21 PM on June 4, 2025, the lunch meal served included mash potatoes and gravy, whereas the posted menu listed roasted potatoes. Per resident interview, it was reported that the meals served frequently do not align with the posted menu. The resident stated that on Wednesday, the menu listed pot pies; however, chicken thighs were served instead, noting disappointment as they had been looking forward to the listed item. The resident further reported that on friday, the menu indicated baked haddock but fried fish sticks were served. The resident expressed that evening meals often do not reflect	R373		

Division of Licensing and Protection

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R373	Continued From page 3 what is posted on the menu and added that BLT sandwiches had been requested for two years and were being served that evening. Per interview with the Food Service Director on the afternoon of June 4, 2025, this finding was confirmed. It was stated that they were not aware of the state rules that the home must follow the written, posted menu.	R373		
R401 SS=F	9.1.a Environment The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This includes outdoor areas that are used by residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews there is a failure to maintain a safe, functional, and sanitary environment as evidenced by the condition of the kitchen sinks, floor, oven top, ice maker, walls, shelves, and all kitchen storage areas. Findings include: Policies and Procedures governing maintenance and cleaning of the home's kitchen environment were not on file and available for review on June 4, 2025. During a tour of the home commencing at 8:25 AM on June 4, 2025, multiple environmental deficiencies were observed in the kitchen. The kitchen floor appeared unclean, with visible dark stains and food particles, and the oven top was coated with hardened food residue. The ice maker faucet was observed to be continuously	R401		

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R401	Continued From page 4 dripping on to the floor, and the three-compartment base sinks were actively leaking into large bins that required frequent emptying to prevent overflow. Additionally, the storage shelves were observed to be unclean. These findings were confirmed by the Facility Manager on the afternoon of June 4, 2025.	R401	VH manager 6/19/2025	

Deficiency Statement Plan of Correction (POC)

Survey Date: June 4, 2025

Facility Name: Vernon Hall Assisted Living Residence

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R213	• As of June 4, 2025, updated VCIC background checks and abuse registry checks have been completed and documented for the five initially identified staff members, as well as for all staff at Vernon Hall, including those providing contracted services. All records have been appropriately updated and securely filed.	06/04/2025	• A tracking system has been developed to monitor the due dates for each staff member's annual background check. • An annual compliance calendar has been instituted to prompt reviews of all mandatory background checks 30 days prior to their due dates.	Human Resources, Facility Manager, and contracted agency department heads. R213 Accepted on 6-25-25 Susan Gregoire RN
R342	• As of June 7, 2025, Vernon Hall Assisted Living has developed and implemented comprehensive written policies and procedures addressing all required service areas. These include: ○ Criminal Record and Abuse Registry Checks: A written protocol outlining the timing, documentation, and retention of background and registry checks for all staff. ○ Medication Administration Training and Delegation: A detailed policy aligned with state guidelines that covers staff training requirements, competency verification, and RN delegation protocols. ○ Staffing Levels: A policy outlining minimum staffing standards. ○ Environmental Cleaning Schedules: Written procedures outlining daily, weekly, and monthly cleaning tasks,	06/17/2025	• All policies and procedures have been compiled into a centralized Policy and Procedure Manual, which is now accessible in the Administrator's office and available for review upon request. The manual is also available digitally on our shared N:/ drive for staff access. • The Facility Manager and department heads will review and update the Policy and Procedure Manual annually. • A formal review schedule has been implemented requiring the Food Service Director, Morning Supervisor, and Evening Supervisor to review and sign off on all updated policies and	Facility Manger, Human Resources, RN Service Coordinator, and Glendale Dining Services R342 Accepted on 6-25-25 Susan Gregoire RN

	responsibilities by department, and documentation logs maintained by the Housekeeping Lead. ○ Maintenance Logs and Equipment Checks: Maintenance procedures now include scheduled equipment inspections and functionality logs reviewed by the Maintenance Supervisor. ○ Menu Planning and Meal Service: Policies have been reviewed and updated by Nutritional Services and incorporated into the Hazard Analysis Critical Control Point (HACCP) binder.		procedures placed in the HACCP binder.	
R373	• Cooks, Shift Supervisors, and the Food Service Director reviewed the menu substitution Standard Operation Procedure (SOP) and expectations for completing the substitution log. • There will be an in-service training on menu substitution log regarding what it is used for and what substitutions can be made to be completed by 7/11/2025. • Resident menu requests will be reviewed by administration and the Dietary Director to ensure consistency with dietary standards appropriate for the elderly population.	07/31/2025	• Written policies and procedures for menu planning, adherence, and substitution documentation have been developed and incorporated into the HACCP binder. • All food service staff will be trained on the regulatory requirement to follow posted menus and to document all substitutions. • A substitution log will be introduced to record any changes to the menu, including the date, reason, and staff signature. • A system for notifying residents of approved menu changes will been implemented to improve communication and satisfaction.	Food and Nutrition Staff and Glendale Service Director. R373 Accepted on 6-25-25 Susan Gregoire RN
R401	• On 6/5/2025 a full deep cleaning of the kitchen was completed, including scrubbing of floors, oven tops, sinks, and all kitchen storage areas.	07/31/2025	• Formal Cleaning and Maintenance Protocols: Written policies and procedures for cleaning and maintaining all kitchen areas—	Administration, and Glendale Service Director.

	• Ice Maker Faucet Repaired: The leaking or continuously running ice maker faucet was repaired on 06/05/2025 to eliminate safety and sanitation concerns. • Leaking pot sink drains is scheduled to be repaired before July 31, 2025 to eliminate safety and sanitation concerns. • Dirty storage shelves will be cleaned by July 19, 2025 to eliminate safety and sanitation concerns. • Staff Training Conducted: All dietary staff received immediate training on the updated cleaning protocols, expectations for maintaining sanitary conditions, and the new documentation procedures. Training logs have been completed and filed. • Policy Accessibility: All cleaning and maintenance policies are now readily accessible in the HACCP binder and available for review.		including sinks, floors, oven tops, walls, ice makers, shelving, and storage—have been reviewed, updated, and added to the facility's HACCP binder. • Daily Cleaning Checklist: A standardized daily cleaning checklist has been implemented to ensure all tasks are completed consistently. Staff must initial and supervisors must sign off upon completion. • Monthly Environmental Inspections: A designated staff member or supervisor will conduct weekly walkthroughs using a standardized inspection form to proactively identify and address any cleanliness or maintenance issues. • Preventive Maintenance Schedule: A routine maintenance schedule has been established for all kitchen appliances and fixtures, including the ice maker, to ensure functionality and sanitary conditions are maintained. • Monthly Administrative Oversight: Results from cleaning checklists and inspection forms will be reviewed during monthly quality assurance meetings.	R401 Accepted on 6-25-25 Susan Gregoire RN