VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

[phone] 802-241-0344
[fax] 802-241-0343

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

June 26, 2025

Valerie Cote, Manager
Allen Harbor Senior Living
90 Allen Road
South Burlington, VT 05403-7856

Dear Ms. Cote:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 11, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0372	A. BUILDING: _____ B. WING _____	C 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEN HARBOR SENIOR LIVING	90 ALLEN ROAD SOUTH BURLINGTON, VT 05403

(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 6/11/25 the Division of Licensing and Protection conducted an investigation of one complaint. The following deficiency was identified during the investigation.	R100	The filing of this plan of correction does not constitute an admission of the allegations set forth in this statement of deficiencies. This plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	
R167 SS=D	5.9.c.(10) Nursing Services For each resident requiring nursing overview, administration of medication, or nursing care, the registered nurse must: Ensure that the resident, licensed health care provider, and, if applicable, the resident's legal representative, are notified immediately when there is an accident or incident involving the resident that results in injury, a significant change in the resident's condition, or a need to alter treatment significantly This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to notify the legal representatives of one applicable resident (Resident #1) regarding a significant change in condition which required medical evaluation and treatment. Findings include: Per record review, Resident #1 has two legal representatives including a Durable Power of Attorney and a Durable Power of Attorney for Health Care. On the early morning of 4/9/25, Resident #1 was transported to the hospital for medical evaluation and treatment. Following a physical examination and diagnostic testing in the emergency department, Resident #1 received IV fluids and instructions for care to manage the signs and symptoms of a gastrointestinal virus.	R167	Emergency contact #1 was updated on Resident #1's change in status later in the day, however, was not documented. The order for emergency contact people has been confirmed again with Resident #1 as of 6/20/2025. Re-education to be completed with nursing staff and all med tech staff on notifying the Resident Representative when someone has a change in condition and/or an incident or accident, in a timely manner, as well as documenting the notification (Significant Change policy). Random audits, by the Executive Director and/or designee, of Resident Representative notifications following a change in condition and/or incident or accident will occur weekly times 4 and then monthly times 3 to ensure continued compliance with the regulation. Results of the audits will be brought to the QA committee for review. R167 Plan of Correction accepted by Jo A Evans RN on 6/24/25	6/27/2025

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R167	Continued From page 1 Per record review there is no documentation in Resident #1's record indicating the Resident's legal representatives were notified by the home regarding transport to the emergency department. During an interview commencing at 2:34 PM on 6/11/25, the Executive Director confirmed Resident #1's legal representatives were not notified regarding this Resident's change in condition and transport to the emergency department.	R167		