VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
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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

July 16, 2025

Wendy Audette, Manager
Heaton Woods
10 Heaton Street
Montpelier, VT 05602-2480

Dear Ms. Audette:

Enclosed is a copy of your acceptable plans of correction for the survey conducted **on June 23, 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
	0297	A. BUILDING: _____ B. WING _____	C 06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATON WOODS	10 HEATON STREET MONTPELIER, VT 05602

(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 June 23, 2025, the Division of Licensing and Protection conducted an unannounced on-site annual survey, which included the investigation of two separate complaints. No regulatory deficiencies were identified related to the complaint investigations, however, the following regulatory deficiencies were identified during the annual survey.	R100	R142 R226 R381 Accepted 7-16-25 Susan Gregoire RN	
R142 SS=E	5.5.d General Care A home must provide each resident with adequate supervision and must facilitate obtaining assistive devices sufficient to prevent accidents, and/or to mitigate risk of injury due to accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to ensure a safe environment by not providing adequate interventions to prevent falls for one applicable resident (Resident #1). Findings include: Upon request, the Manager confirmed that the home did not have a written policy on fall prevention. Per record review on the morning of June 23, 2025, Resident # 1 was admitted to the facility on May 15, 2025. According to the resident's assessment form, the resident is servely impaired in decision-making, has impaired vision, experiences anxiety and requires extensive assistance with all activities of daily living. The assessment further documents that the resident requires the assistance of two staff members for	R142		

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R142	Continued From page 1 all transfers. Per record review of Resident #1's documented incident reports, from the date of admission on May 15, 2025 through June 23, 2025, revealed that the Resident experienced 34 documented unwitnessed falls. This number was confirmed by the House Manager. Per interview with the Home Manager, the facility implemented multiple interventions in an effort to reduce Resident #1's falls.These included changing the Resident's room location, meeting with the Resident's family to discuss fall prevention strategies, providing one-on-one supervision, and obtaining referrals from home health services. Despite these efforts, the Resident continued to experience falls, indicating that the interventions in place were not effective in ensuring a safe environment or preventing further incidents.	R142		
R226 SS=E	5.12.b.(5) Records/Records The home must keep and maintain the following records: A written report of any accident, incident, or illness involving a resident must be placed in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the Home failed to maintain completed written reports of accidents and incidents in resident records as required by State Rules. Findings include:	R226		

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R226	Continued From page 2 Upon request, the Home did not have a policy on completing accident and incident reports. Per record review conducted on the morning of June 23, 2025, accident and incident report documentation was found to be incomplete for four out of four reports reviewed, specifically incident numbers 669, 700, 701, and 709. During an interview conducted at 10:43 AM on June 23, 2025, the Medical Technician (Med Tech) expressed surprise that some of the reports, dating back over a week, remained incomplete, stating that the facility training requires them to be completed promptly. Both the Med Tech and the Nurse confirmed that incident reports are expected to be completed during the shift in which the incident occurs to ensure timely and accurate documentation. Per interview with the Manager the afternoon of June 23, 2025, it was confirmed that accident and incident reports had not been completed in accordance with State Rules.	R226		
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.	R381		

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R381	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the home failed to ensure that all perishable food was properly labeled, dated and stored in closed sanitary packaging as required by State Rules. Findings include: The Home's Policy, Storage of Food Products states that all food products will be stored in such a manner as to minimize the risk of spoilage or contamination. Additionally, the policy specifies that all food will be covered when stored. Per observation during the facility tour the morning of June 23, 2025, multiple food items were found to be improperly stored. A chocolate cake was observed inside a torn plastic bag, spilling out of a plastic tub, with a partially torn and illegible date label. Several loaves of bread were not dated, and the bags were left open. Multiple bags of cereal were also observed open and without date labels. Additionally, a large plastic container of dijon mustard was noted to have residue smeared across the top and sides, creating an unclean and unsanitary appearance. The Kitchen Manager confirmed theses findings at 10:06 AM on June 23, 2025.	R381		

Deficiency Statement Plan of Correction (POC)

Survey Date:

Facility Name:

Deficiency Regulation		How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R142 R142 Accepted on 7-16-25 Susan Gregoire RN		Continue current interventions. Family to provide a 1:1 care through private agencies during identified hours of increased fall risk. Provide a new fall policy. Continue regular care planning meetings with family. Re referral to PT and staff safety evaluations by Home Health agency.	8/1/2025	New policies and regular education are provided by the new clinical team and new DON.	The clinical team that consists of RN's/ DON.
R226 R226 Accepted on 7-16-25 Susan Gregoire RN		Provide a new policy on writing incident and accident reports.	8/1/2025	New policies and regular education will be provided by the new clinical team and new DON	The clinical team that consists of RN's/ DON
R381 R381 Accepted on 7-16-25 Susan Gregoire RN		All food/drink will be labeled and dated after opening. All food and drink will be labeled/dated as well as put in an adequate container. Re educate Kitchen staff and review regulations.	8/1/2025	Educated the kitchen manager on regulations.	The Executive Director and leadership team.
