VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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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 23, 2025

Shannon Robtoy, Manager
Ethan Allen Residence
1200 North Avenue
Burlington, VT 05408-2777

Dear Ms. Robtoy:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 25, 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
	0128	A. BUILDING: _____ B. WING _____	C 06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ETHAN ALLEN RESIDENCE	1200 NORTH AVENUE BURLINGTON, VT 05408

(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 6/25/25 the Division of Licensing and Protection conducted an unannounced on-site annual survey and an investigation of one facility reported incident. Findings include:	R100	Plan of correction for all tags accepted by Jo A Evans RN on 7/22/25. Please refer to the attached document to review the accepted corrective actions for all deficiencies cited. A Please see attached deficiency Statement plan of correction form.	
R151 SS=E	5.7.c Assessment Each resident must also be reassessed annually and at any point in which there is a significant change in the resident's physical or mental condition, as defined in the instructional guide with the assessment instrument, available on the DLP website. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review Resident Assessments were not completed as required for 2 applicable residents (Residents #1 and #2). Findings include: The home's Admission Agreement effective June 2025 states the home provides nursing care in accordance with state rules and a nurse is always available to review assessments of each resident. The home's Resident Admission policy, which was provided for review by the Director of Nursing and Administrator on request for the home's policies and procedures governing Resident Assessments, does not indicate Residents Assessments will be completed annually and when there is a significant change in a resident's physical or mental condition. Resident Assessments were not completed as required for Resident #1 and Resident #2 as	R151		

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R151	Continued From page 1 follows: 1. Per Progress Notes, on 3/14/25 Resident #1 received a new diagnosis of breast cancer and palliative care was initiated. Per review of Resident Assessments on file in Resident #1's record, a Resident Assessment was not completed by a facility RN in response to this significant change. 2. Per record review Resident #2 was admitted to the home on 10/16/23. Resident Assessments on file in Resident #2's record do not include an annual assessment completed in 2024. On the afternoon of 6/25/25 the Director of Nursing confirmed Resident Assessments were not completed as required for Resident #1 and Resident #2.	R151		
R193 SS=F	5.10.d (2) Medication Management A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents. Delegation must be resident (1) specific for each medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure the Registered Nurse delegates responsibility for medication administration prior to permitting designated staff to administer specific medications to specific residents of the home. Findings include: The home's Delegation of Medication	R193		

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R193	Continued From page 2 Administration policy effective 8/29/14 states, "The Director of Nursing (DON)has the authority and responsibility of implementing and monitoring the delegation process to ensure safe, accurate medication administration by trained unlicensed medication technicians." During an interview on the morning of 6/25/25 the Director of Nursing stated the home's medication administration training process routinely includes staff in training administering medications under the supervision of an experienced Med Tech. At 11:20 AM the Director of Nursing confirmed staff in training administer medications under the supervision of experienced Med Techs prior to the Director of Nursing completing an observed med pass to verify the competency and safe medication administration practices of the staff in training. At 1:22 PM on 6/25/25, a Med Tech who was observed training another Staff member during the noon med pass stated they are responsible for training other staff to administer medications; and confirmed on the third day of the medication administration training process the Staff in training typically administers medications to residents under their supervision.	R193		
R199 SS=F	5.10.d.(6) Medication Management Insulin and other injectable diabetes medications. Staff other than a nurse may administer injections only when: i. The condition and medication regimen of the person with diabetes is considered stable by the registered nurse who is responsible for delegating the administration, which must be	R199		

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R199	Continued From page 3 documented by the current delegating nurse in the medical record; and ii. The designated staff to administer injections to the resident have received additional training in the administration of injections, including the use of various injection vehicles (syringes, insulin pens, etc.), and return demonstration, and the registered nurse has deemed them competent and documented that assessment; and iii. The registered nurse monitors the resident's condition regularly and is available when changes in condition or medication might occur. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the Registered Nurse failed to ensure competency in the skills Medication Technician's are expected to perform related insulin administration. Findings include: The home's Staff Training for Health Related Services policy effective March 2025 includes procedures which state, "The RN should oversee all staff training for health-related tasks and procedures and ensure that staff maintain competency in these tasks." Per record review of the home's Medication Delegation Sign Off form, skills related to administration of insulin are not included on this checklist. During the noon med pass on 6/25/25, the Med Tech on duty was observed attaching a disposable needle to a Novolog Flex insulin pen without first sanitizing the pen's rubber seal, which is the area of an insulin pen where the disposable needle is attached. When questioned	R199		

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R199	Continued From page 4 by the Surveyor, the Med Tech indicated they were not aware that sanitizing the rubber seal before attaching the needle is part of the procedure for preparing a pen for insulin administration. The Med Tech on duty was observed to be providing medication administration training for another staff member while preparing the insulin pen for administration. On the afternoon of 6/25/25 the Director of Nursing confirmed sanitizing the rubber seal of an insulin pen prior to attaching the disposable needle is included in the home's procedures for insulin administration; and acknowledged the Med Tech's failure to perform this task is potential risk of infection for residents receiving insulin.	R199		
R202 SS=F	5.10.g Medication Management Homes must establish procedures for documentation sufficient to indicate to the licensed health care provider, registered nurse, manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this must include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a registered nurse has delegated administration; and (5) For residents receiving psychoactive	R202		

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R202	Continued From page 5 medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure handling of insulin pens in accordance with currently accepted professional standards of practice. Findings include: The home's Assisting with Insulin Administration policy states, "a) Medication technician will receive additional /on-going training and supervision when give the task of administering insulin. [sic]" 1. When an insulin pen is opened, the current professional standard is to label the pen with the date it was opened to prevent use of this medication beyond the expiration date. According to the American Diabetes Association website, disposable insulin pens are discarded after the pen has been in use for 28-32 days depending on the type of insulin. Individual insulin pens are labeled with the date they are first "opened" to ensure they are discarded within a set period of time are they are removed from the refrigerator for use. The home's Assisting with Insulin Administration policy does not instruct Medication technicians to label insulin pens with the date the pens are opened. During observation of the noon med pass at the first floor medication cart insulin pens including 2 Novolog Flex Pens and a Lantus Solostar insulin pens were observed to be opened and in use	R202		

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R202	Continued From page 6 without labels indicating the date the pens were opened. This finding was confirmed by the Med Tech on duty at the first floor med cart during the noon med pass on 6/25/25, and acknowledged by the Director of Nursing on the afternoon of 6/25/25. 2. The current professional standard is to clean the rubber seal of an insulin pen with an alcohol swab prior to attaching the disposable needle as an infection control intervention. The home's Assisting with Insulin Administration policy does not include insulin administration procedures. During the noon med pass on 6/25/25, the Med Tech on duty was observed attaching a disposable needle to a Novolog Flex insulin pen without first sanitizing the pen's rubber seal, which is the area on the body of an insulin pen where the disposable needle is attached. The Med Tech stated sanitizing the hub before attaching the needle is not part of the procedure for preparing a pen for insulin administration. On the afternoon of 6/25/25 the Director of Nursing confirmed sanitizing the rubber seal of an insulin pen prior to attaching the disposable needle is included in the home's procedures for insulin administration; and acknowledged the Med Tech's failure to perform this task is potential risk of infection for residents receiving insulin.	R202		
R203 SS=F	5.10.h (1) Medication Management All drugs, medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of	R203		

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R203	Continued From page 7 practice. Medication must be used only for the resident identified on the pharmacy label. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel must have access to the keys. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews there is a failure to ensure medications managed by the home are stored in locked compartments. Findings include: On the afternoon of 6/25/25 the Administrator and Director of Nursing confirmed policies and procedures governing secure storage of medication in locked compartments have not been developed by the home. Medications managed by the home were observed to be unsecured and accessible to residents as follows: 1. At 11:45 AM on 6/25/25 a key was observed to be left in door knob locking mechanism of a supply closet with a sign posted above the door knob which stated, "Do not leave key in door". The Administrator was present and immediately removed the key from the door. The Administrator confirmed medications including 2 tubes of Diclofenac Sodium 1% Topical Gel, 1 bottle of Nystatin 100,000 units/gram Powder and 1 tube of Nystatin 100,000 units/gram Cream were left unsecured and accessible to residents in closet. 2. At 2:25 PM on 6/25/25 a medication cabinet on	R203		

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R203	Continued From page 8 the first floor of the home was observed to be left unlocked and open. The medication cart drawers were filled with topical medications, wound care supplies, and prescription strength fluoride toothpaste belonging to residents of the home. At approximately 2:30 PM on 6/25/25 the Med Tech on duty stated the last time they recalled observing the cabinet to be locked was at 12:15 PM the same day, and confirmed medications stored in the unlocked cabinet were unsecured and accessible to residents.	R203		
R210 SS=F	5.11.c Staff Services The home must provide, or arrange for the provision of, at least twelve (12) hours of training upon hire and each year to each staff person providing direct care to residents. The manager may give credit towards the required 12 hours of training upon hire, for any formal training received in the twelve months preceding the date of hire, provided the home maintains documentation of the training and ensures competency in the subject matter. 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, hand washing, handling of linens, maintaining clean environments, blood borne	R210		

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R210	Continued From page 9 pathogens and universal precautions; (7) General supervision and care of residents; (8)Communication strategies, person-centered care, challenging behaviors and understanding dementia; (9) Recognition of and sensitivity to different cultures, belief systems, abilities, gender identities, sexual orientation; and (10) Trauma-informed care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review 3 out of 5 sampled staff did not complete all required yearly trainings. Findings include: The home's policy governing required staff training effective March 2025 is consistent with the current licensing rules. On the afternoon of 6/25/25 the Administrator and Director of Nursing were requested to provide documentation of completed trainings for a sample of 5 staff. Per review of the documents provided, 3 out of 5 sampled staff did not complete the required yearly trainings. Per record review, 3 out of 5 staff did not complete the required Resident Emergency Response Procedures and First Aid training; and 1 out of 5 sampled staff did not complete the required General Care and Supervision training. These findings were confirmed by the Director of Nursing at 3:36 PM on 6/25/25, and by the Administrator during a review of findings on the afternoon of 6/25/25.	R210		

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R225	Continued From page 10	R225		
R225 SS=F	5.12. b (4) Records/Reports The home must keep and maintain the following records: 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 interviews and record review all required criminal record and abuse registry checks were not completed for 4 out of 5 sampled staff. Findings include: The home's Employee Background Checks policy indicates the required background checks will be completed "per state regulation". On the afternoon of 6/25/25 the Administrator was requested to provide documentation of criminal record and abuse registry checks completed for a sample of 5 staff. Per review of the documentation provided by the Administrator, background checks were not completed as required for 4 out of 5 sampled staff. This finding was confirmed by the Administrator at 3:16 PM and reconfirmed at 5:35 PM on 6/25/25.	R225		
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.	R342		

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R342	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to develop policies and procedures governing areas of service provided by the home. Findings include: Per staff interview and record review, Staff #1 was employed at the home as a Licensed Practical Nurse (LPN). Staff #1's Vermont LPN license was due to be renewed on 1/31/2024; however, according to public records on file on the Vermont Office of Professional Regulations website Staff #1's LPN license was not renewed until 1/31/2025. During an interview commencing at 4:27 PM on 6/25/25, the home's Administrator and Director of Nursing confirmed Staff #1 worked as an LPN at the home during the time period between 1/31/24 - 1/31/25 without an active professional license. Per review of a report made to the licensing agency, Staff #1 was terminated from their LPN position at the home when the Executive Director was notified on 1/27/25 by Staff #1, that they had forgotten to renew their nursing license. Per interview with the Executive Director on 6/25/25, it was confirmed the home does not have a policy and procedure in place to ensure all licensed staff's professional licenses remain in good standing and are active, and the home did not perform any kind of check to ensure professionally licensed staff #1 maintained active licensure. Per Staff interview, following this incident the home instituted changes to include the Director of Operations reminding professionally licensed staff to renew their license, verifying renewals, and documenting professional license renewal. In addition to this, throughout the annual survey conducted on 6/25/25 the Administrator and	R342		

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R342	Continued From page 12 Director of Nursing were requested to provide policies and procedures governing the following areas of service: 1. Secure storage of medications managed by the home in locked compartments 2. Grievances 3. Secure storage of hazardous substances including cleaning chemicals 4. Maintenance of the home's living environment including plumbing fixtures 5. Quarterly reporting of resident's personal funds managed by the home Per staff interview and record review policies and procedures governing the areas of service provided by the home listed above were not on file and available for review on request. These findings were confirmed by the Administrator on the afternoon of 6/25/25.	R342		
R356 SS=C	6.8 Resident's Rights A resident may complain or voice a grievance without interference, coercion or reprisal. Each home must establish a written grievance procedure for resolving residents ' concerns or complaints that is explained to residents at the time of admission. The grievance procedure must include at a minimum, time frames, a process for responding to residents in writing, and a method by which each resident filing a complaint will be made aware of the role and contact information of the Office of the Long-Term Care Ombudsman and Disability Rights Vermont as an alternative or in addition to the home's grievance mechanism. This REQUIREMENT is not met as evidenced	R356		

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R356	Continued From page 13 by: Based on observation, staff interview, and record review there is a failure to maintain the home's written grievance procedure on file and available for review. Findings include: On the morning of 6/25/25 the home's Administrator was requested to provide a copy of the home's Admission Agreement for review. Page 6 of the home's Admission Agreement effective June 2025 provided for review in response to this request states the organization that manages the home has a written grievance procedure that is explained at the time of admission. A written grievance procedure developed by the home or the organization that manages the home is not included in the Admission Agreement provided by the Administrator for review. During the annual survey conducted at the home on 6/25/25 the Administrator was requested to identify the pubic area where the home's written grievance procedure is posted. At 4:25 PM on 6/25/25 the Administrator confirmed the home's grievance procedure was not posted as required; and confirmed a written Grievance procedure had not been developed by the home.	R356		
R401 SS=D	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:	R401		

Administrator 7/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ETHAN ALLEN RESIDENCE	1200 NORTH AVENUE BURLINGTON, VT 05408

(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
R401	Continued From page 14 Based on observation and staff interviews there is a failure to ensure care in a safe environment related to unsecured chemicals accessible to residents. Findings include: On the afternoon of 6/25/25 the Administrator and Director of Nursing confirmed policies and procedures governing secure storage of hazardous substances including cleaning chemicals in locked compartments have not been developed by the home. In a resident Bathroom on the first floor of the home gallons of Zep High-Traffic Carpet Spot Remover & Cleaner, and Zep All Purpose Carpet Shampoo were observed to be stored in an unlocked cabinet under the vanity sink, and a spray bottle of Skintegrity Wound Cleanser was observed to be stored in an unlocked vanity drawer at 2:22 PM on 6/25/25. These findings were confirmed by the Director of Nursing at approximately 2:40 PM on 6/25/25.	R401		
R427 SS=F	9.6.a Plumbing All plumbing must operate in such a manner as to prevent back-siphonage and cross-connections between potable and non-potable water. All plumbing fixtures and any part of the water distribution or sewage disposal system must operate properly and be maintained in good repair. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure the first floor bathroom	R427		

Administrator 7/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ETHAN ALLEN RESIDENCE	1200 NORTH AVENUE BURLINGTON, VT 05408

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R427	Continued From page 15 maintained an operable sink . Findings include: Policies and procedures governing maintenance of the home's environment including plumbing fixtures were not on file and available for review on request. At 2:21 PM on 6/25/25 bathroom on the first floor of the home was observed without an operable sink. The sink built-in to the cover of the toilet tank in this bathroom is non-operable as it is not connected to a water supply and there is no faucet attached to the sink. This bathroom was observed to be accessible to all residents, visitors, and staff. On the afternoon of 6/25/25 the Director of Nursing confirmed this finding and stated the shower in this bathroom is used for hand washing.	R427		
R455 SS=C	11.2 Resident Funds and Property If the home manages the resident's finances, the home must keep a record of all transactions, provide the resident with a quarterly statement, and keep all resident funds separate from the home or licensee's funds. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to provide quarterly statements to all applicable residents for whom the home manages personal funds or their responsible parties. Findings include: The home's Standard Operating Procedure for handling of resident petty cash provided by the Administrator for review on the afternoon of 6/25/25 does not include policies and procedures	R455		

Administrator 7/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ETHAN ALLEN RESIDENCE	1200 NORTH AVENUE BURLINGTON, VT 05408

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R455	Continued From page 16 governing provision of quarterly statements. On the afternoon of 6/25/25 the Administrator was requested to provide documentation of quarterly statements provided to residents for whom the home manages personal funds or their responsible parties. At 4:40 PM the Administrator confirmed the home does not provide the required quarterly statements regarding personal funds for all applicable residents.	R455		

Administrator 7/21/2025

Deficiency Statement Plan of Correction (POC)

Survey Date: 6/25/2025

Facility Name: Ethan Allen Residence

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R151	All resident assessments will be reviewed to ensure they are up to date.	8/21/25	Policy updated for facility on resident assessments.	DON
R193	All medication delegation now started with orienting with the registered nurse	8/21/25	Medication delegation policy updated, and process changed.	DON
R199	Updated medication delegation skills sign off form and all current medication delegated staff re-delegated and signed off on by RN.	8/21/25	Medication delegation policy updated, and new delegation skills sign off implemented.	DON
R202	New process/policy implemented for routine monitoring of all items in medication cart for expiration and appropriate labeling per policy.	8/21/25	New policy in place for storage and monitoring of expired medications.	DON
R203	Education to all medication delegated staff on appropriate storage of medications.	8/21/25	New policy in place for storage and monitoring of expirations of medications.	DON
R342	Due to lack of valid license this individual is no longer employed with the residence.	1/28/25	New policy for monitoring professional licensures was put into place.	Director of operations
R210	All staff mandatory in-services will be reviewed to ensure completion.	8/21/25	Staff in-services will be completed upon hire and then annually per policy.	Director of operations
R225	A new process is implemented to ensure all new hire and annual background checks are completed.	8/21/25	Staff background checks will be completed upon hire and then annually per policy.	Director of Operations
R356	Grievance policy was updated and posted in facility.	8/21/25	Policy in place to ensure continuity.	Administrator
R401	Reeducated staff on safe chemical storage. All cleaning products/chemicals are locked in housekeeping closets.	8/21/25	All staff reeducated on safe chemical storage and will educate all new staff upon hire per new policy.	Administrator
R427	A sink was installed in the bathroom.	8/21/25	Maintenance will ensure the sink is always functioning properly.	Administrator & Maintenance
R455	All residents' will be sent a quarterly statement for resident petty cash.	8/21/25	Policy updated for facility to send quarterly updates.	Administrator

All corrective actions listed above accepted by Jo A Evans RN on 7/12/25