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

September 29, 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 **September 16, 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 _____ | R-C 09/16/2025 |

| 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<br><br>On 9/16/25 the Division of Licensing and Protection conducted an unannounced on-site investigation of one facility reported incident and a follow-up survey subsequent to a finding of immediate jeopardy to all residents of the home during an investigation conducted on 8/28/25 and 9/2/25 requiring an immediate corrective action plan.<br><br>During the follow-up survey conducted on 9/16/25, the immediate jeopardy was determined to be removed. The following deficiency was identified related to the complaint investigation: | R100 | | |
| R151 SS=D | 5.7.c Assessment<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review there is a failure to complete Resident Assessments as required for one applicable resident (Resident #1). Findings include:<br><br>1. Per record review, the single Resident Assessment on file in Resident #1's record is an admission assessment signed as completed on 9/5/24 by a Registered Nurse. This admission assessment on file indicates Resident #1 is never verbally or physically abusive to self or others and Resident #1 never exhibits socially inappropriate | R151 | | |

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| R151 | Continued From page 1<br>or disruptive behaviors. This Resident Assessment documented Resident #1's weight on admission, and indicated Resident #1 was not receiving Home Health Services when admitted to the home.<br><br>Per record review Resident #1 has experienced and demonstrated significant changes while residing at the home. Progress Notes on file indicate Resident #1 frequently exhibits behaviors including verbal and physical aggressions towards others, as well as disruptive and socially inappropriate behaviors.<br><br>Progress Notes also document significant changes for Resident #1 including:<br>a. Initiation of physical therapy, occupational therapy, and skilled nursing Home Health Services on 11/15/25<br>b. Changes in eating habits resulting in significant weight loss of 8 pounds in one month documented on 11/19/25<br>c. A loss of 17.4 pounds since admission documented on 12/29/25<br>d. Initiation of hospice services documented on 3/28/25<br><br>Per record review, significant change assessments were not completed for Resident #1 in response to the significant changes documented in their resident record.<br><br>2. Per record review, an annual assessment was due to be completed for Resident #1 on 9/5/25. As of 9/16/25 a completed annual assessment was not on file and available for review in Resident #1's record.<br><br>On the afternoon of 9/16/25 the Executive | R151 | Plan of Correction accepted by Jo A Evans RN on 9/26/25<br><br>Please refer to the attached document to review the accepted plan. | |

Division of Licensing and Protection

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| R151 | Continued From page 2<br>Director confirmed an annual Resident Assessment and significant change Resident Assessments were not completed for Resident #1. | R151 | | |

## Deficiency Statement Plan of Correction (POC)

**Survey Date: 9/16/25**

**Facility Name: Heaton Woods Residence**

| 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 |
|---|---|---|---|---|---|
| R151 | All resident assessments will be reviewed to ensure they are up to date. Any requiring update will be completed. | All resident assessments will be reviewed to ensure they are up to date. | 10/26/25 | Policy updated for facility on resident assessments. | DON |
| | | | | | |

Plan of Correction accepted by Jo A. Evans RN on 9/26/25