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

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
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

October 3, 2025

Anne Steinberg
Michaud Memorial Manor
47 Herrick Road
Derby Line, VT 05830-8759

Dear . Steinberg:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 15, 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
	0143	A. BUILDING: _____ B. WING _____	C 09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAUD MEMORIAL MANOR	47 HERRICK ROAD DERBY LINE, VT 05830

(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 9/15/25 the Division of Licensing and Protection conducted on unannounced on-site annual relicensure survey and an investigation of one facility reported incident. There were no deficiencies identified related to the facility reported incident. The following deficiencies were identified during the annual relicensure survey:	R100	Corrective actions for all tags cited accepted by Jo A Evans RN on 10/2/25. See Attached Deficiency Plan of Correction Template	
R151 SS=D	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 there is a failure to ensure completion of a significant change assessment as required for one applicable resident (Resident #3). Findings include: The home's Resident Nursing Assessment policy is consistent with this licensing requirement. Per interview with the Executive Director commencing at approximately 12:15 PM on 9/15/25, Resident #3 receives home health hospice services which were initiated after admission to the home. Resident #3's record does not include a Resident Assessment completed in response to this significant change. This finding was confirmed by the Executive Director on the afternoon of 9/15/25.	R151		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0143	A. BUILDING: _____ B. WING _____	C 09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAUD MEMORIAL MANOR	47 HERRICK ROAD DERBY LINE, VT 05830

(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
R162 SS=F	5.9.c (5) Nursing Services For each resident requiring nursing overview, administration of medication, or nursing care, the registered nurse must: Maintain a current list for review by staff and physician of all residents' medications. The list must include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure medication orders for all residents of the home include a specific dose and a specific frequency of administration to include the amount of time between PRN (as needed) doses. Findings include: The home's Nursing Overview policy is consistent with this licensing requirement. 1. Per review of the home's standing orders for PRN (as needed) medications for all residents of the home, the following orders do not include a specific dose and/or frequency of administration for medications including: a. Colace 100 mg cap 1-2 capsules up to twice a day as needed b. Senna "8.5 mg" tab 1-2 capsules up to twice a day as needed	R162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0143	A. BUILDING: _____ B. WING _____	C 09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAUD MEMORIAL MANOR	47 HERRICK ROAD DERBY LINE, VT 05830

(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
R162	Continued From page 2 c. Maalox 30 cc by mouth up to four times a day as needed d. TUMS (Calcium Carbonate 500 mg) Chew 2 tabs by mouth up to 3 times a day as needed e. Cough Drops- allow one lozenge to dissolve in mouth - Per package directions as needed for sore throat or cough. f. Apply Bacitracin 0.9 gram ointment - apply topically as needed up to 4 times a day until resolved g. Minerin (medication used as a moisturizer), Zinc Oxide (medicated cream), Menthol (topical analgesic medication) and Miconazole cream or powder (anti-fungal medication) appear on a list with moisturizers and skin protectants with instructions above this list that states, "For General Skin Care Use any brand skin treatment or preventative with ingredients or any combination of ingredients ..." h. Hydrocortisone 1% topical cream - apply thin layer to affected area up to three times a day as needed ... i. Nystatin topical powder and topical cream 100,000 grams apply a thin layer to affected area until rash or itching resolved j. Insta-Glucose (24 gram) Gel- administer as directed by mouth for hypoglycemic episode less than 70. k. "May Start probiotic supplement acidophilus- 1 cap twice a day as needed During length of Antibiotic administration"	R162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0143	A. BUILDING: _____ B. WING _____	C 09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAUD MEMORIAL MANOR	47 HERRICK ROAD DERBY LINE, VT 05830

(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
R162	Continued From page 3 l. "Topical Biofreeze (menthol)- apply topically affected to area up to 3 times a day" m.. "Icy Hot (Menthol and or Methly salicylate)- apply topically to affected area up to 3 times a day" n. "Ear Wax Removal 1. Use of any brand ear wax removal/softener drops, use per Package instructions 2. Flush with Water and Hydrogen Peroxide Solution" 2. Per review of September the 2025 Medication Administration Records for a sample of 3 staff, medications not included on the home's standing orders without a specific dose and frequency of administration were identified for 3 out of 3 sampled residents (Residents #1, #2, and #3) including: For Resident #1: a."Antacid Liq Red Str (Mylanta) ..." 30 cc by mouth up to four times daily as needed for upset stomach For Resident #2: a. Ipratropium-Albuterol 0.5-3 mg/3 ml One Unit Dose via nebulizer four times daily as needed for Shortness of Breath/Wheezing For Resident #3: a. Lidocaine Patch 4% Use as directed three times daily as needed for pain, b."Prochlorperazine Rectal Suppository 25 Insert 1 suppository rectally every 12 hours as needed for Nausea and vomiting"	R162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0143	A. BUILDING: _____ B. WING _____	C 09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAUD MEMORIAL MANOR	47 HERRICK ROAD DERBY LINE, VT 05830

(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
R162	Continued From page 4 c."Salonpas Patch Box 60 (Camphor-Menthol-Methyl Salicylate)" Apply topically to affected area three times daily as needed for Pain These findings were confirmed by the Director of Nursing in training on the afternoon of 9/15/25.	R162		
R191 SS=D	5.10.c Medication Management Staff must not administer any medication, prescription or over-the-counter medications for which there is not a written, signed order from a licensed health care provider and a supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure written signed precriber's orders were obtained for medications administered to 1 applicable residents (Resident #3). Findings include: The home's Handling and Administration of Medications policy is consistent with this licensing requirement. Per record review, prescriber's written, signed orders were not on file and available for review for the following medications listed in Resident #3's September 2025 Medication Administration Records: 1. Lidocaine Patch 4% Use as directed three times daily as needed for pain	R191		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0143	A. BUILDING: _____ B. WING _____	C 09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAUD MEMORIAL MANOR	47 HERRICK ROAD DERBY LINE, VT 05830

(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
R191	Continued From page 5 2. "Prochlorperazine Rectal Suppository 25 Insert 1 suppository rectally every 12 hours as needed for Nausea and vomiting" 3. "Salonpas Patch Box 60 (Camphor-Menthol-Methyl Salicylate)" Apply topically to affected area three times daily as needed for Pain This finding was confirmed by the Director of Nursing in training at approximately 2:00 PM on 9/15/25.	R191		
R206 SS=E	5.10.h (4) Medication Management Medications left after the death or discharge of a resident, or outdated medications, must be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, there is a failure to dispose of medications per the home's policies and procedures: The home's Medication Disposal policy states, "Medication, in all forms, must be disposed of when it is refused by a resident, is outdated, becomes contaminated, or the resident is discharged and/or expires. Disposal of medications must occur soon after the determination of the need to do so ..." During a review of the medications stored in the home's medication cart the following expired medications were observed to be stored with	R206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0143	A. BUILDING: _____ B. WING _____	C 09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAUD MEMORIAL MANOR	47 HERRICK ROAD DERBY LINE, VT 05830

(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
R206	Continued From page 6 medications to be administered to residents of the home: 1. Jardiance 25 mg tablets expired on 5/4/25 belonging to Resident #4 2. Famotidine 10 mg tablets expired on 7/14/25 belonging to Resident #5 3. Docusate Sodium (DSS) 100 mg capsules expired on 7/1/25 belonging to Resident #6 This finding was confirmed by the Med Tech on duty and the Executive Director on the afternoon of 9/15/25.	R206		
R224 SS=D	5.12.b (3) Records/Reports The home must keep and maintain the following records: For residents requiring nursing care, including nursing overview or medication management, the record must also contain: initial assessment; annual reassessment; significant change assessment; licensed health care provider ' s admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of licensed health care provider visits, signed telephone or electronic orders and treatment documentation; and resident plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure one applicable resident's record includes all required documentation (Resident #3). Findings include: The home's policies are consistent with this	R224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0143	A. BUILDING: _____ B. WING _____	C 09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAUD MEMORIAL MANOR	47 HERRICK ROAD DERBY LINE, VT 05830

(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
R224	Continued From page 7 licensing regulation. Per interview with the Executive Director commencing at approximately 12:15 PM on 9/15/25, Resident #3 receives home health hospice services which were initiated after admission to the home. Per record review, during the survey conducted on 9/15/25 required documentation was not on file and available for review in Resident #3's record related to hospice services including a significant change Resident Assessment completed in response to initiation hospice care; Progress Notes documenting the date of Resident #3's admission into hospice care; a hospice plan of care and a hospice medication list with signed orders for prescribed hospice medications. On the afternoon of 9/15/25, the Executive Director confirmed required documentation related to Resident #3's hospice care was not on file and available for review in Resident #3's record.	R224		
R999 SS=F	Miscellaneous This REQUIREMENT is not met as evidenced by: 1.8 License Required The terms residential care home, assisted living, or assisted living residence or words to that effect may not be used by any facility in its title, brochure, admission agreement, or other written or promotional materials unless the facility has a valid license to operate as a residential care home or assisted living residence issued by the Department of Disabilities, Aging and Independent Living.	R999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0143	A. BUILDING: _____ B. WING _____	C 09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAUD MEMORIAL MANOR	47 HERRICK ROAD DERBY LINE, VT 05830

(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
R999	Continued From page 8 Based on observation, staff interview and record review this licensing requirement is NOT MET as evidenced by misrepresentation of the Residential Care Home as an "Assisted Living Facility" in the home's Admission Orders form. Findings include: Per record review, the home is licensed to operate as a Residential Care Home by the Vermont Division of Licensing and Protection. On the afternoon of 9/15/25 the home's Admission Orders form, which is sent to a resident's providers during the admission process, was observed with the words "Admission ORDERS FOR Level III Assisted Living Facility" written below the home's name, address, telephone number, and fax number. Per interview on the afternoon of 9/15/25, the Executive Director was not aware this form was in use. The Executive Director confirmed this finding on the afternoon of 9/15/25 .	R999		

Deficiency Statement Plan of Correction (POC)

Survey Date: 9/15/25

Facility Name: Michaud Memorial Manor

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 Plan of correction accepted by Jo A Evans RN on 10/2/25	A change of status assessment has been completed for resident #3 to reflect the admission to hospice in May 2025.	At this time, no other residents in the Home are receiving hospice care; however the new Director of Nursing is aware that, going forward, anyone who is admitted to Hospice must have a change of status assessment completed at that time.	9/30/25	The Director of Nursing or designee will conduct an audit at least quarterly of all residents to ensure that no one is admitted to hospice without a change of status assessment being completed.	Director of Nursing
R162 Plan of correction accepted by Jo A Evans RN on 10/2/25	The standing orders form and the orders for the three sampled residents have been updated and all medications with parameters have been changed to reflect specific dosage and frequency. New, corrected orders have been faxed to all resident primary care physicians, as of 9/22/25 for signature and are in the process of being signed and returned.	The Director of Nursing is in the process of reviewing all other resident medications, to ensure that there are a specific dosage and frequency listed for all, and any discrepancies will be sent to the physician for correction.	To be completed no later than 10/31/25	The Director of Nursing will conduct quarterly audits on all medications to ensure there is a signed physician's order with a specific dose and frequency for each medication.	Director of Nursing

R191 Plan of correction accepted by Jo A Evans RN on 10/2/25	The order for resident #3 "Salonpas Patch Box 60 (Camphor-Menthol-Methyl Salicylate)" Apply topically to affected area three times daily as needed for Pain" and "Lidocaine Patch 4% Use as directed three times daily as needed for pain were found to be duplicate orders; the resident only uses the Salonpas patches and the order was found in the paper chart. The order for the Salonpas has been scanned into the resident's chart and the duplicate Lidocaine patch order has been removed. The order for resident #3 "Prochlorperazine Rectal Suppository 25 Insert 1 suppository rectally every 12 hours as needed for Nausea and vomiting" was found to be prescribed by a doctor in the ED. After the survey the order was found to have been scanned in the resident's chart under Hospital Discharge Orders. This order was moved to the Physician's Orders section.	The Director of Nursing will conduct an audit of all resident charts to ensure all orders have a signed prescription from the provider who prescribed the medication.	To be completed no later than 10/31/25	Going forward, any new orders received from the Emergency Department will be scanned into the electronic medical record and saved under the Physician's Orders section instead of the Hospital Discharge Orders section. The Director of Nursing or designee will conduct an audit at least quarterly of all residents to ensure that all orders have a prescription that is signed by the provider who prescribed the medication.	Director of Nursing
R206	All expired medications that were discovered on the day of the inspection	The Director of Nursing conducted an audit of the rest of the medication cart to	10/2/2025	The Director of Nursing or designee will do weekly audits of the medication cart to ensure that	Director of Nursing

R206 cont. Plan of correction accepted by Jo A Evans RN on 10/2/25	have been disposed of per facility policy.	ensure that there were no other expired medications, with no additional findings. All facility staff who administer medications have been educated on the policy regarding destruction of expired medications.		there are no expired medications present in the cart.	
R224 Plan of correction accepted by Jo A Evans RN on 10/2/25	Signed physician orders were obtained for prescribed hospice medications and scanned into the electronic medical record on 9/24/25. The Director of Nursing completed a change of status assessment reflecting the admission to hospice and wrote a late entry progress note. A hospice plan of care has been developed and is part of the resident's medical record.	At this time, no other residents in the Home are receiving hospice care; however, going forward, the Director of Nursing or designee will ensure all required documentation is completed and maintained in the resident's medical record, including but not limited to a change of status assessment, a progress note, hospice plan of care and signed physician orders.	10/2/2025	The Director of Nursing or designee will conduct an audit any time a resident is admitted to hospice to ensure that all required documentation is completed and maintained in the resident's medical record.	Director of Nursing
R999 Plan of correction accepted by Jo A Evans RN on 10/2/25	The form that stated "Assisted Living Facility" has been updated to state "Level III Residential Care Home".	An audit of all other facility forms was conducted to ensure that all representation of the facility was as a Level III Residential Care Home. During this audit, no other misrepresentations were identified.	9/25/25	Staff have been educated that any newly created documents must list the Home as a Level III Residential Care Home and must be approved by the Administrator prior to use.	Administrator

Anne Sinclair, Administrator
10/2/25