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

October 24, 2025

Eric Bach, Manager
Canterbury Inn
46 Cherry Street
Saint Johnsbury, VT 05819-2290

Dear Mr. Bach:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 29, 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
	0119	A. BUILDING: _____ B. WING _____	C 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY INN	46 CHERRY STREET SAINT JOHNSBURY, VT 05819

(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 9/29/25 the Division of Licensing and Protection conducted an unannounced on site investigation of one facility reported incident and two complaints. The following deficiencies were identified:	R100	Corrective actions for all deficiencies cited approved by Jo A Evans RN on 10/23/25. Please refer to the attached document to review the approved corrective actions.	
R142 SS=D	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 there is a failure to provide adequate supervision to mitigate the risk of injury for one applicable resident with an identified risk for wandering and elopement (Resident #1). Findings include: The home's policies and procedures governing resident safety checks were not provided for review as requested on the morning of 9/29/25. At 5:30 PM on 9/29/25 the home's Director stated the home has a policy for 2-hour safety checks to be completed for residents of the home. Per interviews with the home's Director and Director of Nursing conducted on the afternoon of 9/29/25, and per review of the facility's written reports and letters, Resident #1 wandered away from the home on the afternoon of 8/13/25 and was unaccounted for until the morning of 8/14/25 when the Resident was found on the fire escape of a building in the community. Per police call records and the facility's written reports, Resident	R142		

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R142	Continued From page 1 #1 was transported to the Emergency Department for evaluation, and discharged back to the home on the morning of 8/14/25. Per hospital discharge paperwork, on the morning of 8/14/25 Resident #1 was seen at the emergency department for "Fall ", "Contusion of left leg" and "Contusion of right wrist". The facility's written report of the incident submitted to the licensing agency stated Resident #1 "... apparently fell with no major injury, contusion and abrasion noted." A Progress Note dated 8/25/25 indicated a "large bruise-hematoma" remained on Resident #1's left upper thigh from a fall on 8/13/25. Resident #1 does not recall when or why they wandered away from the home, or where they were during the time period they were unaccounted for between the afternoon of 8/13/25 and the morning of 8/14/25. Per review of the facility's written report to the licensing agency and a letter from the Director to the applicable Resident's family member dated 8/14/25, approximately 3 weeks prior to Resident #1's unexplained absence from the home this Resident was evaluated by their Neurologist who identified a rapid increase in Alzheimer's symptoms and recommended the Resident move to a memory care or locked facility, which led to concerns that Resident #1 would begin to wander on the community. During an interview commencing at 5:00 PM on 9/29/25, the Director of the home confirmed as of 8/13/25 safety checks were conducted for Resident #1 every 2 hours, which is the standard frequency of safety checks completed for all residents of the home, indicating when Resident #1 wandered away from the home increased safety monitoring had not been implemented in response to the Resident's rapid decline and identified need for a higher level of care. An entry in Resident #1's Care Plan	R142		

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R142	Continued From page 2 dated 8/14/25 instructs staff to check on Resident #1's location every 2 hours, and an entry dated 9/1/25 indicates "1-on-1 care staff for evenings implemented through family (4:00 PM - 8:00 PM) nightly". During the interview on the afternoon of 9/29/25, the home's Director and Director of Nursing confirmed following the incident of Resident #1 wandering away from the facility on 8/13/25 the Resident's family hired a private duty caregiver to provide 1-to-1 care between 4:00 PM - 8:00 PM four days a week; an "air tag" was purchased to track Resident #1's location; and Resident #1 was moved to a first floor room. There is no documentation in Resident #1's Care Plan and Progress Notes indicating the frequency of safety checks conducted for Resident #1 by facility staff has been increased from the standard 2-hour checks implemented for all residents of the home.	R142		
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 there is a failure to complete Resident Assessments as required for 2 applicable residents (Resident #1 and Resident #2). Findings include:	R151		

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R151	Continued From page 3 Per staff interview and record review Resident Assessments were not completed as required for Resident #1 and Resident #2 as follows: 1. Resident #1's record included one completed Resident Assessment which was an admission assessment completed within 14 days of this Resident's admission to the home in July of 2024. As of 9/29/25 an annual assessment had not been completed as required for Resident #1. The admission assessment on file for Resident #1 indicated this Resident had minimal difficulty remembering, and wandered mostly inside. A box indicating Resident #1 wanders outside, leaves and gets lost was not checked on this assessment form. On the afternoon of 8/13/25 Resident #1 wandered away from the home and was unaccounted for until the following morning. When Resident #1 was located they were unable to recall when or why they left the home and where they had been during the time they were unaccounted for. Per record review, approximately 3 weeks prior to Resident #1's unexplained absence from the home on 8/13/25 Resident #1's Neurologist identified a rapid increase in the signs and symptoms of Alzheimer's Dementia which indicated a need for a higher level of care. Additionally, on 9/9/25 Resident #1 was admitted into Palliative Care. Per record review, a Resident Assessment was not completed in response to these significant changes. 2. Resident #2 was hospitalized from 2/18/25-2/27/25 following a heart attack, and was discharged back to the home with orders for new medications to regulate blood clotting, and Nitroglycerin to treat episodes of poor blood flow	R151		

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R151	Continued From page 4 to the heart muscle. Home health services were also ordered for Resident #2 on discharge from the hospital including physical therapy for a home safety evaluation and a home exercise program "for endurance, gait stability and strength with mobility and transfers"; and occupational therapy for assessment and management of activities of daily living. Per record review, a Resident Assessment was not completed for Resident #2 in response to these significant changes. These findings were confirmed by the Director of Nursing on the afternoon of 9/29/25.	R151		
R194 SS=F	5.10.d (3) Medication Management The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and iv. Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions regarding medication administration and documentation. v. Ensuring that all applicable staff are trained and delegated before the staff are permitted to administer any newly prescribed medication to any resident.	R194		

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R194	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews there is a failure for the Registered Nurse responsible for proper administration of medications to teach designated staff techniques for medication administration. Findings include: The home's Delegation of Administration of Medications policy states the Registered Nurse is responsible for "Delegating the responsibility of the administration of medications by unlicensed Care Team member. [sic]". This policy also states the Registered Nurse is responsible for instructing and assessing designated staff, including "Proper techniques for medication administration." During an interview conducted on the afternoon of 9/29/25 the Director of Nursing, responsible for nursing oversight at the home, stated the medication administration training process includes Med Tech trainees preparing and administering medications for residents of the home under the supervision of the Med Tech Supervisor who is not a Registered Nurse. At 2:44 PM on 9/29/25 the Director of Nursing confirmed Med Tech trainees perform the nursing task of preparing and administering medications under the supervision of a staff member other than a Registered Nurse prior to the Director of Nursing determining the Med Tech in training's medication administration practices are safe an effective, and delegating the Med Tech trainee to administer specific medications to specific residents of the home.	R194		

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R202	Continued From page 6	R202		
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 medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to administer medications as ordered for 5 applicable residents (Resident's #2, #3, #4, and #5). Findings include: The home's Orders policy indicates the purpose of this policy is "To ensure all medications and treatments provided for residents by (the home's) staff will be done so according to a provider's valid order. "	R202		

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R202	Continued From page 7 The home's Administering Medications policy instructs staff to always follow the "Five Rights" of medication administration to include the right resident, medication, dose, route (method of administration) and time. Per review of Medication Error Reporting Forms on file at the home, the following medications were not administered as ordered: 1. On 6/9/25 Resident #2 was given the wrong dose of the anticoagulant medication Coumadin. The prescriber ordered 2 mg ordered, 3 mg were given. The Medication Error Reporting Form dose not identify possible causes for this error. At 4:07 PM on 9/29/25 the Director of Nursing confirmed error resulted from incorrect transcription of the prescriber's order. 2. On 8/28/25 Resident #3 was not given the medication Atorvastatin (regulates cholesterol) as ordered. The Medication Error Reporting Form does not identify possible causes for this error. 3. On 5/31/25 Resident #4 was given the wrong medication. The anxiety medication Klonopin was given when the combination pain medication of Hydrocodone/Acetaminophen was prescribed. The Medication Error Reporting Form indicates this error resulted from staff "Failure to adhere to work policy/procedures". 4. On 6/20/25 Resident #5 was not given the medication Pregabalin (treats neurological disorders) as ordered. This medication error occurred again on 7/13/25. Medication Error Reporting Forms indicate the same Med Tech was responsible for both of these errors and two additional medication errors. The reporting forms indicate these errors resulted from "Lack of knowledge/experience" and "Failure to adhere to	R202		

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R202	Continued From page 8 work policy/procedures". 5. On 7/13/25-7/14/25 Resident #6 was not given the medication Magnesium as ordered. The Medication Error Reporting Form indicates this error resulted from staff "Failure to adhere to work policy/procedures". On the afternoon of 9/29/25 the Director of Nursing, who is the Registered Nurse responsible for nursing oversight of the home confirmed these findings.	R202		
R229 SS=D	5.12.c (3) Records/Reports A home must file the following reports with the licensing agency: Any unexplained absence of a resident from a home for more than two (2) hours must be reported to the police, legal representative and family, if any. The incident must be reported to the licensing agency within twelve (12) hours of disappearance, followed by a written report within forty-eight (48) hours, a copy of which must be maintained. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to notify the licensing agency within 12 hours regarding one applicable resident's unexplained absence from the home (Resident #1). Findings include: The home's Elopement Missing Resident policy	R229		

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R229	Continued From page 9 indicates "Licensing and Protection" will be notified by the Director "as appropriate" when a resident is missing. This policy does not identify the minimal requirement to report to the licensing agency within 12 hours of a resident's disappearance. Per record review, Resident #1's diagnoses included memory impairment that was in rapid decline prior to the Resident wandering away from the home on the afternoon of 8/13/25. Per staff interview and record review, Resident #1 wandered away from the home on the afternoon of 8/13/25 and was missing until the morning of 8/14/25. Per record review, there are varying reports of when Resident #1 was last accounted for on 8/13/25. A copy of the local police department's record of calls related to this incident provided by the Director for review during the investigation conducted on 9/29/25 indicates the staff who reported Resident #1 was missing stated this Resident was last seen by staff at 1:00 PM on 8/13/25. A letter written by the Director to Resident #1's responsible party dated 8/14/25 indicates the Resident was last seen by staff at 2:30 PM on 8/13/25; and reports submitted by the home to the licensing agency and to the Department of Aging and Independent Living indicate Resident #1 was last accounted for at 3:00 PM on 8/13/25. Per interview with the home's Director on the afternoon of 9/29/25, Resident #1 was last seen by staff on 8/13/25 during afternoon activities which ended at 3:30 PM, and Resident #1 was observed to be missing from the home when staff noticed this Resident was not present for dinner at approximately 5:00 PM on 8/13/25. Per staff	R229		

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R229	Continued From page 10 interview and record review Resident #1 was found on a fire escape of a building in the community at approximately 6:00 AM on 8/14/25. Per staff interview and record review, the home's Director and Director of Nursing submitted a report to the licensing agency regarding this incident at 10:54 AM on 8/14/25. During an interview commencing at 5:00 PM on 9/29/25 the Director confirmed the licensing agency was not notified within 12 hours regarding Resident #1's unexplained absence from the home as required.	R229		

Deficiency Statement Plan of Correction (POC)

Survey Date: September 29, 2025

Facility Name: Canterbury Inn

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
R142 Plan of correction accepted by Jo A Evans RN on 10/23/25	Policy governing resident safety checks created	Assessments will now result in safety check intervals being added to care plans. All residents will be assessed by PCP in October and November resulting in the assessment and care plan updates.	10/13/25 – 12/1/25	New policy created to outline use of safety checks.	Manager/DON
R151 Plan of correction accepted by Jo A Evans RN on 10/23/25	Both resident #1 and number #2 have had updated assessments.	All residents have been reviewed and no others were found to be unassessed for either an annual assessment or for a significant change.	10/3/25	A spreadsheet has been created to track annual assessments has been created.	DON and newly hired LPN.
R194 Plan of correction accepted by Jo A Evans RN on 10/23/25	All medication delegated staff have met with DON for a review and refresher of medication management, medication administration and a review of medication errors.	n/a	10/16/25	New policy for training delegated staff has been created for DON to personally supervise the training of new staff prior to receiving delegation and the support ongoing support of the regularly scheduled delegated staff.	DON
R202 Plan of correction accepted by Jo A Evans RN on 10/23/25	Individual responsible for three of the five medication errors was dismissed on 8/4/25. The other medication errors have been addressed with the	New policy for order acceptance and for high-risk medications is now in place. New medication error report form has been developed to more accurately trace error causes.	10/21/25	New policies in place. New policies have been reviewed with delegated staff. Existing med errors were specifically reviewed with staff.	DON

	providers and a policy update has been made with a follow-up letter to providers regarding our policy and our inability to accept orders not appropriately written or completed for any period of time.				
R229 Plan of correction accepted by Jo A Evans RN on 10/23/25	Updated Policy for Elopement	DLP to be notified by email at AHS.DAILSCIntake@vermont.gov with basic information regarding elopement prior to 12 hour mark.	10/1/25	Written into policy.	Manager