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

November 13, 2025

Sabrina Krafchuk, Manager
Vernon Assisted Living Residence
13 Greenway Drive
Vernon, VT 05354

Dear Ms. Krafchuk:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 22, 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
	1006	A. BUILDING: _____ B. WING _____	C 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON ASSISTED LIVING RESIDENCE	13 GREENWAY DRIVE VERNON, VT 05354

(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 10/22/25, the Division of Licensing and Protection conducted an unannounced on site investigation of one facility reported incident. The following deficiency was identified:	R100		
R360 SS=D	6.12 Resident's Rights Residents must be free from mental, verbal or physical abuse, neglect, and exploitation. Residents must also be free from restraints and seclusion as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one resident (Resident #1) was free from abuse. Per record review Residents #1's care plan dated 2/13/25, identifies that Resident #1 has a cognitive deficit or decline, persistent anger with self or others, unpleasant mood in the morning, demonstrates ineffective coping skills, and gets fixed on one thought and not easy to redirect or distract. Interventions include monitor resident frequently. The care plan also identifies that Resident #1 wanders. Further review of Resident #1 ' s record revealed a progress note dated 4/20/25 at 2:42 PM. Resident #1 was very upset and told a staff member that while they were in Resident #2's room they had been hit by Resident #2 in the face with a closed fist. The staff contacted the RN and manager, and Resident #1 was asked to stay away from Resident #2 for their safety, and other shifts would be informed. There were no other interventions implemented at this time to protect	R360	**How the deficiency was corrected** • Resident #2 has received an order to be seen by psych services; MediTelecare. • Policies on documentation procedures were reviewed and revised. • Resident #1 was discharged to Memory Care facility on 7.23.25. **How other potential residents identified, and corrective action taken** • Monitor Residents for behaviors and notify physicians of significant changes. • Education to nursing staff on documentation procedures. • Review resident level of care monthly. • Discuss resident behaviors at morning huddles. **System changes to ensure compliance of the regulation** • Weekly audit x2 months will be completed to monitor documentation tasks are being completed when assigned.	11.13.2025

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R360	Continued From page 1 Resident #1 from potential abuse. Per review of the facility policy titled "Resident Abuse, Neglect, Exploitation and Misappropriation of resident property" dated 9/23/24, it defines physical abuse as "hitting, slapping, pinching and kicking ...". Additionally, it mentions that this facility will "ensure that residents who have either reported, or who have been the alleged victim ... are protected from ... subsequent exposure ...". This policy also states "Department head and/or Supervisor will be apprised of the incident and will monitor the safety of the resident. Such monitoring will include surveillance of any resident, family member, staff member, visitor or volunteer who may be suspected of potentially intimidating, questioning or harming the resident ..." Per review of the facility's Initial Report provided by the facility Manager, dated 4/20/25 at 2:00 PM, it states that the physical abuse between Resident #1 and Resident #2 occurred on 4/20/25 at 10:00 AM. The report identifies Resident #1 as the alleged victim and Resident #2 as the alleged perpetrator. The Initial Report mentions that Resident #1 had stated that Resident #2 had hit them with a closed fist to the face in Resident #2's room. The report also mentions that they did not see any physical injury, but Resident #1 said "the area was tender". It does not identify what area on Resident #1 's face was tender. Additionally, the report references the progress note dated 4/20/25 at 2:42 PM. The report also acknowledges that Resident #1 was instructed to stay away from Resident #2, but that Resident #1 was found in Resident #2's room later that evening, "RA ' s (Resident Assistant) did immediate assessment of resident and reported to administration and there were no physical	R360	**Who will monitor to ensure compliance** • The RN Service Coordinator, RA's, VH Manager, will provide ongoing monitoring of this process to ensure compliance. Results of this will be brought to QAPI and/or until 100% compliance is achieved. R360 approved by LTCM on 11-13-2025	

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R360	Continued From page 2 signs of injury. Resident did feel safe and was told that it would be best to give other resident space while we sorted this all out. Resident was found to be in the alleged perpetrator ' s room later that evening. RN (Registered Nurse) Service Coordinator and Manager met with both individuals the next day to begin conducting the formal interview". Another progress note dated 4/20/25 at 9:52 PM, seven hours after the initial allegation of abuse, states that Resident #1 was found going into another Resident's room that they had been asked not to go into for safety. The note further reveals that the writer asked the Resident #1 to come away from other Resident #2's room and talked to the Resident #1 about personal safety and why they were being asked to stay away from the other Resident for the time being until the situation between the both of them had been resolved. The progress notes states "writer told res that res safety is writers ' number 1 priority and would like res to stay safe." The writer then left Resident #1 unsupervised and then found Resident #1 standing over Resident #2 that was sleeping in a chair. Resident #1 was asked again to stay away from Resident #2. Resident #1 did admit that Resident #2 had put hands on them in this progress note, which appeared to be referring to the incident earlier in the day. There were no additional interventions implemented at this time to protect Resident #1 from additional potential abuse. Per record review of a progress note dated 4/21/25 at 11:15 AM, Resident #1 reported to Staff and the Manager that the other Resident (Resident #2), had not hit Resident #1, but "did say that other resident [Resident #2] had grabbed [Resident #1] by the arms and shook [Resident	R360		

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R360	Continued From page 3 #1] once". Per review of the Follow Up Investigation Report dated 4/21/25, it revealed that Resident #1 had been shaken by Resident #2. The facility investigation states that Resident #1 acknowledged that Resident #2 had "grabbed and shaken [them]" and that Resident #2 "admitted to shaking [them]". It states that Resident #2 said that they might have accidentally elbowed Resident #1 in the face. The RN Service coordinator and Facility Manager noted that a bruise was observed below Resident #1's left eye, but that it appeared to be older, and Resident #1 reported it was from the bathroom mirror. The report also states that both residents have been diagnosed with memory impairment and that (Resident #1) also had a new diagnosis for which Resident #1 had declined treatment, which had caused Resident #1 to appear increasingly confused in recent days. In the report, the facilities investigation results were "inconclusive", with a statement saying, according to Resident #2, the incident did occur, despite the victim denying it the following day. This report also identified what corrective actions would be taken, and it states, Resident Assistants will conduct random room checks whenever both residents are in the room together. Per interview with the Assistant Administrator on 10/22/25 at 3:40 PM, they confirmed that according to the facilities investigations, Resident #2 had put their hands on Resident #1 and shaken them. The Assistant Administrator stated that the two of them were encouraged to be separated, monitored, and take space from each other as an intervention. The Assistant Administrator also confirmed they were lacking documentation of the random checks being completed and were unsure of how long the checks were supposed to be occurringfor, as	R360		

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R360	Continued From page 4 identified in the corrective action plan from the follow-up investigation report. The Assistant Administrator was able to provide documentation of "night checks," however, there were no additional checks documented.	R360		