VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
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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

December 31, 2025

Darshane Campbell, Manager
Single Steps
62 Barre Street
Montpelier, VT 05602-3508

Dear Ms. Campbell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 2, 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
	0153	A. BUILDING: _____ B. WING _____	C 12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINGLE STEPS	62 BARRE 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 On 12/2/25 the Division of Licensing and Protection conducted an unannounced on site annual survey and investigation of one facility reported incident. The following deficiencies were identified:	R100		
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 complete a significant change Resident Assessment in response to a decline in one applicable resident's physical abilities and condition (Resident #3). Findings include: Per record review the most recent Resident Assessment on file for Resident #3 was signed as completed by the former Registered Nurse on 2/2025. This annual Assessment indicates Resident #3 is independent with mobility in bed and toileting; is independent with supervision for transfers, dressing, and bathing; requires supervision and limited assistance for locomotion in the home; and requires only supervision with personal hygiene. During an interview commencing at 2:55 PM on 12/2/25, the Manager confirmed Resident #3 had frequent falls and requires assistance with all	R151		

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R151	Continued From page 1 ADLs including bathing, dressing, meal prep, and standing; and is unable to get into bed or toilet independently. Per the Manager, Resident #3 does not perform any personal hygiene tasks independently, if standing up with their walker Resident #3 struggles to stand up and is unable to get their walker if it is out of their reach, during med administration Resident #3 struggles to stand with only one hand on their walker as they take their meds with the other hand, and requires the assistance of 2 staff to walk without their walker. During an interview conducted at 4:20 PM on 12/2/25 Resident #3 was observed by the surveyor to require the Manager's assistance to prevent loss of balance when transitioning from a seated position to a standing position with their walker placed directly in front of them. At 4:08 PM on 12/2/25, the Manager confirmed a significant change assessment was not completed by the former Registered Nurse in repose to changes in Resident #3's the decline in Resident #3's physical abilities since the annual Resident Assessment was competed on 2/20/25. Please refer to tag 463.	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	R193		

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R193	Continued From page 2 by: Based on Staff interview and record review there is a failure to ensure all of the home's staff have been delegated the responsibility of administering specific medication to designated residents of the home. Findings include: Policies and procedures governing nursing oversight and delegation of nursing tasks were not on file and available for review on request. Per interview with the Manager on the afternoon of 12/2/25, all of the home's staff are responsible for the administration of medications to residents of the home. At 12:08 PM on 12/2/25 the Manager confirmed the Registered Nurse who delegated this nursing task to all of the home's staff had not been employed at the home since 11/7/25, and the staff had not been redelegated by another Registered Nurse employed at the home since the previous nurse's employment ended.	R193		
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;	R210		

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R210	Continued From page 3 (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 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 there is a failure to ensure 5 out of 5 sampled staff completed the required yearly trainings. Findings include: Policies and procedures governing staff training provided for review are not consistent with the current regulatory requirements. On the afternoon of 12/2/25 the Manager was requested to provide documentation of trainings completed by 5 sampled staff. Per review of the documentation provided by the Manager, the required yearly trainings were not completed by 5 out of 5 sampled staff. This finding was confirmed by the Manager at 2:40 PM on 12/2/25.	R210		

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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 interview and record review there is a failure to ensure the required criminal background checks were completed for 5 out of 5 sampled staff. Findings include: Policies and procedures governing staff background checks were not on file and available for review on request. On the afternoon of 12/2/25 the Manager was requested to provide documentation of criminal record and abuse registry checks for a sample of 5 staff. Per review of the documentation provided by the Manager, Vermont Criminal Information Center checks were not completed in 2025 as required for 5 out of 5 sampled staff. This finding was confirmed by the Manager at 2:15 PM on 12/2/25.	R225		
R369 SS=F	7.1.a.(1) Menus and Nutritional Standards The home must provide each resident with a nourishing, palatable, well-balanced diet that meets their daily nutritional and special dietary needs, taking into account the preferences of each resident. This REQUIREMENT is not met as evidenced by:	R369		

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R369	Continued From page 5 Based on observation, staff interview, and record review there is a failure to ensure the planned weekly menu of meals provided by the home adequately meets resident's nutritional needs. Findings include: Policies and procedures governing Nutrition and Food Services have not been developed by the home. The My Plate Plan included in the United States Food and Drug Administration's Dietary Guidelines for Americans 2020-2025 emphasizes the importance of eating a variety of fruits, vegetables, grains, dairy or fortified soy alternatives, and protein foods; and encourages a "make every bite count" approach to eating including the choice of foods and beverages that are full of nutrients. Per interview with the Manager conducted on the morning of 12/2/25 and review of a sample of 5 weekly menus, the home does not prepare 3 nutritious meals for the home's residents daily as required in a Residential Care Home; and the foods and beverages listed on the home's menus do not provide a variety nutrient-dense foods to meet the nutritional needs of the home's residents. Per review of a sample of 5 recent planned weekly menus on file at the home: 1. The same items are offered for breakfast every morning to include "Bagel/toast, Fruit, Milk, OJ, Oatmeal Water, Cereal, Decaf Coffee, Yogurt, Eggs". 2. The same items are offered for lunch every afternoon to include "Cold cuts, Bread, Cheese,	R369		

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R369	Continued From page 6 Lettuce, Juice, Water, Soup, Peanut Butter, Jelly, Yogurt, Milk, Decaf Coffee, Tea" Per the Manager, the residents these items are available for residents to prepare their own breakfast and lunch, and staff will assist if a resident requests their help. 3. Dinners listed on a sample of recent planned menus included incomplete meals which often listing only a single item such as Pizza, Lasagna, Fish Sticks, Ravioli, Meatloaf, or Steak Fries. Dinners were also listed as "Leftovers" or "Staff Choice" on the sampled menus. Per the Manager, the residents are expected to plan and prepare dinners for the home with staff assistance if needed or requested. This finding was confirmed by the Manager of the home at 1:10 PM on 12/2/25.	R369		
R401 SS=F	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: Based on observation and staff interview there is a failure to provide care in a safe, functional, sanitary, homelike and comfortable environment. Findings include: Policies and procedures governing maintenance of the home's living environment provided for	R401		

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R401	Continued From page 7 review were limited to an incomplete list of staff duties. Per observation on arrival to the home and during a tour of the home commencing at 11:10 on the morning of 12/2/25, the living environment was observed to be poorly maintained and with safety concerns including: a. The kitchen sink was observed to be full of dirty dishes at approximately 11:00 AM. b. The interior and exterior of the home's refrigerator, counter tops, appliances and food items to be consumed by residents of the home were observed dried food spills, crumbs, and stains. c. Soiled rags, towels and mop heads were piled on a shelf and on the floor in the kitchen. d. A seating area between the kitchen and living room was observed with tables covered with opened food containers, food crumbs, art supplies, trash bags and resident's personal items. e. A bathroom on the second floor of the home was observed with resident's uncovered personal razors and tooth brushes piled together in the vanity drawers. This is a risk for injury due to exposed razor blades and a risk for infection . f. The shared bathrooms on the second floor of the home were observed to be unclean and in poor repair, and with a toilet plunger on the floor of a bathroom covered with dried toilet paper. g. Resident #1's room was unclean and in disrepair with dirty dishes and clothing on the	R401		

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R401	Continued From page 8 furniture and floor; dirt, debris and stains on the floor, walls, mattress, and furniture; and a multi outlet extension cord with cords and small appliances strewn on the floor. h. The bed frame in Resident #3's room was observed with a poorly fitted mattress leaving the edges of the metal frame exposed. A built in wooden structure constructed by the home, which was attached to a wall to prevent movement or removal, prevented the placement of Resident #3's bed against the wall to allow adequate space for ambulation with a walker and arrangement of items in the room to reduce risk for falls and injuries. These findings were confirmed by the Manager during the tour of the home conducted on the morning of 12/2/25, with the exception of example h. which was confirmed by the Manager at 4:08 PM on 12/2/25.	R401		
R424 SS=F	9.4.d Recreation and Dining Rooms Smoking is not permitted in any area of the home, with the exception of the manager's living quarters if the manager lives onsite. The home may designate an area outside the home as a smoking area, so long as its location does not have a negative impact on the residents and staff, and noncombustible safety-designed ashtrays or receptacles are provided. This REQUIREMENT is not met as evidenced by:	R424		

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R424	Continued From page 9 Per observation and staff interview there is a failure to ensure 2 residents (Residents #1 and Resident #2) do not smoke in their rooms. Findings include: The Admission Packet provided to residents during the admission process indicates smoking is not permitted in the home. At 11:33 AM on Resident #1's room was observed to have an odor of smoke and other evidence of smoking including a plate used as an ash tray; ashes and ash stains on the window sill, furniture and flooring; cigarette boxes, tobacco, smoking paraphernalia and a dried green plant material on a plate with a lighter. The Manager of the home was present during the tour of Resident #1's room, and confirmed Resident #1 smoking in their room is an ongoing issue. On the afternoon of 12/12/25 the Manager also confirmed Resident #2 also smokes in their room.	R424		
R430 SS=F	9.6.d Plumbing Hot water temperatures must not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure the water temperature in an office bathroom accessible to residents of the home is maintained at or below 120 degrees Fahrenheit. Findings include: Policies and procedures governing water temperatures in resident specific areas of the home were not on file and available for review on	R430		

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R430	Continued From page 10 request. On the afternoon of 12/2/25 the water temperature in the staff office bathroom was observed to be maintained at 125 degrees Fahrenheit. This office is accessible to residents of the home when they are receiving care in the office. This finding was confirmed by the Program Manager at PM on 12/2/25. Policies and procedures governing water temperatures in resident accessible areas of the home have not been developed. After adjustments made to the home's water heating system made by the Maintenance staff for the organization that manages the home on the afternoon of 12/2/25, the water temperature in the staff office bathroom was observed and confirmed to be maintained at or below 120 degrees Fahrenheit.	R430		
R463 SS=D	12.1.a Nursing Home Level of Care The provision of nursing home level of care means the provision of services that require specialized knowledge, judgment and skill, all of which meet the standards of nursing as set forth in 26 V.S.A. Chapter 28. A home that wishes to admit or retain a resident who requires nursing home level of care must obtain prior written approval from the licensing agency in the form of a variance and must demonstrate to the licensing agency's satisfaction that it has the capacity to provide the necessary care and services. Enhanced Residential Care providers must provide the services agreed to in the Enhanced Residential Care provider agreement with the state of Vermont and outlined in their Admissions	R463		

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R463	Continued From page 11 Agreements with ERC residents This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review there is a failure to ensure a variance was obtained from the licensing agency to retain one applicable resident (Resident #3) in response to significant changes which are indicative of a need for nursing home level of care. Findings include: Policies and procedures governing admitting and retaining residents with needs meeting the requirements for nursing home level of care have not been developed by the home. Per record review the most recent Resident Assessment on file for Resident #3 was signed as completed by the former Registered Nurse on 2/20/25. This annual Assessment indicates Resident #3 is independent with mobility in bed and toileting; is independent with supervision for transfers, dressing, and bathing; requires supervision and limited assistance for locomotion in the home; and requires only supervision with personal hygiene. Per a Plan of Care signed by the former Registered Nurse and the Manager, in July of 2025 Resident#3 was able to ambulate independently with a wheeled walker; however, this Resident had an unsteady gait and used their walker for support during transfers, was unable to use stairs to move between floors of the home, and required staff support to safely navigate 2 stairs to transition from the home's porch to the driveway. This care plan indicates that as of July 2025 Resident #3 was still able to toilet and dress independently; however, they required staff assistance with bathing to ensure safe transfers	R463		

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R463	Continued From page 12 in and out of the shower, maintain balance and safety when bending and reaching, and required staff to wash areas of their body they were unable to reach. An additional fall specific care plan was created by the former Registered Nurse on 8/6/25 to specifically address Resident #3's risk for injury due to decreased mobility and frequent falls related to an "increased unsteady gait". Per interview with the Manager commencing at 2:55 PM on 12/2/25, Resident #3 has sustained multiple falls including falls with injuries due to difficulty getting out of bed without pulling bedding off the bed and tripping on it, loss of balance, and generalized weakness. Injuries sustained during falls include a fractured breast bone on 8/5/25, a finger laceration requiring medical evaluation in the emergency department on 10/1/24, and a fall from bed on 11/10/25 resulting in a bump on the back of their head which was observed by the Surveyor to remain present during an interview with Resident #3 on the afternoon of 12/2/25. During the interview on the afternoon of 12/2/25, the Manager confirmed Resident #3 currently requires assistance with all ADLs including bathing, dressing, meal prep, and standing; and is unable to get into bed or toilet independently. Per the Manager, Resident #3 does not perform any personal hygiene tasks independently, struggles to stand up independently and is unable to get their walker if it is out of reach. The Manager further stated that during med administration Resident #3 struggles to stand with only one hand on their walker as they take their meds with the other hand, and requires the assistance of 2 staff to walk without their walker. During an interview conducted at 4:20 PM on 12/2/25 Resident #3 was observed by the Surveyor to require the Manager's assistance to	R463		

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R463	Continued From page 13 prevent loss of balance when transitioning from a seated position to a standing position with their walker placed directly in front of them. Additionally, per the Manager, Resident #3 also demonstrates needs related to their mental health diagnosis and frequently demonstrates behaviors which require redirection. Per the Manager, and per record review, Resident #3 does not have a diagnosis of dementia; however, Resident #3 demonstrates significant difficulty with long and short term memory and has moderately impaired ability to make decisions regarding tasks of daily life. . Per record review, the home has not applied for or received a variance to retain Resident #3 due to significant changes in condition indicative of nursing home level of care. Per interview on the afternoon of 12/2/25, the Manager stated they were not aware of the requirement to obtain a variance from the licensing agency when a resident requires a nursing home level of care. These findings were confirmed by the Manager of the home at 4:08 PM on 12/2/25.	R463		

Deficiency Statement Plan of Correction (POC)

Survey Date: December 2, 2025

Facility Name: WCMHS' Single Steps

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	Nurse to complete a new assessment	All current resident assessments will be reviewed and updated as needed	1/9/2026	Assessment due dates to be written on calendar to remain in compliance of the regulation.	Program Nurse, Program Manager R151 accepted by LTCM 12-30-25
R193	Program Nurse to delegate all current staff	Nurse-led staff meeting to conduct a group delegation. Alternative dates and times to be offered for one-on-one delegations	1/9/2026	Medication Delegation policies and procedures to reflect changes in Nursing staff.	Program Nurse, Program Manager R193 accepted by LTCM 12-30-25
R210	Each staff to meet with Program Manager to review their current trainings and their missing ones. Staff to sign up for their missing one by 1/9/26	Program Manager to remind staff monthly of their expired trainings through one on one supervision meetings.	1/2/2026	Program Manager to do a quarterly review of all residential staff trainings. Reminder to be set on Program Manager's schedule.	Program Manager R210 accepted by LTCM 12-30-25
R225	WCMHS is obtaining VCIC criminal background checks for the five affected employees who had previously been screened only through the Paycom background package. Results will be reviewed by HR and placed in each applicable	WCMHS will conduct an audit of all other employees in the Single Steps program to identify any additional employees working in the home who were hired during the period Paycom was used as a "one-stop" package and verified that each has an agency-run VCIC check on file.	12/26/2025	For internal use, a background check rubric was created to summarize requirements, by funding source and program for future reference when onboarding new hires. This rubric serves as a background check procedure which revised to state that VCIC background checks must be requested and received directly by WCMHS	-The Assistant Director of HR Operations, or designee, will review the new hire and background check checklist to verify VCIC documentation for all new hires prior to approval to

	employee's file, confirming that all required VCIC checks are now complete and compliant with DAIL Background Check Policy.			(not through a third-party package) all employees in DAIL-funded homes, as required by DAIL Background Check Policy. The Paycom background package is no longer used as the sole background check method; the VCIC request and result are tracked on an a background check checklist, which must be completed for all new employees. R225 accepted by LTCM 12-30-25	begin in a DAIL-funded home. WCMHS has hired a full-time HR Administrator who will conduct the background checks in accordance with regulatory requirements and will monitor compliance through a quarterly audit of sample personnel and household files. -Program Manager
R369	Program Manager and Program Nurse reviewed with Staff what makes a balanced diet. Reviewed the My Plate Plan from the US FDA	Staff to complete menus with appropriate balanced meals weekly.	12/29/2025	Program Manager to review menus weekly prior to their post to ensure meals contain a balance of fruits, vegetables, grains, dairy and alternative choices.	Program Manager R369 accepted by LTCM 12-30-25
R401	Staff of the program thoroughly cleaned kitchen, and both bathrooms. New bed frame requested for resident #3.	Staff to complete weekly bedroom checks, and nightly bathroom cleaning to ensure a safe and habitable environment. Kitchen checks will continue to be completed throughout the day but with record to ensure completion.	12/29/2025	Program Manager to review record of weekly, nightly and daily checks, on a daily basis.	Program Manager R401 accepted by LTCM 12-30-25
R424	Program Manager reminded residents not	Staff to complete daily bedroom checks to	12/29/2025	Program Manager to review bedrooms weekly in	Program Manager

	to smoke in their room through review of their residential contract and signs in their bedrooms. A more sensitive smoke detector was installed on 12/22/25	ensure residents are not smoking in their bedrooms. Staff to educate residents on the hazards of smoking indoors.		conjunction with Program Staff to search for evidence of smoking indoors.	R424 accepted by LTCM 12-30-25
R430	Program Manager to create a water temperature policy and procedure and add it to Staff's weekly duties.	Purchase of a water temperature thermometer, and record chart created to reflect weekly checks.	12/29/2025	Program Staff to Monitor temperatures weekly	Program Manager R430 accepted by LTCM 12-30-25
R463	Nurse to work with Program Manager to complete assessment to determine the best environment for resident #3 as, according to DLP, they meet nursing home level of care.	Meeting with resident #3, family, Program Manager, Division Manager, and Nurse to be held on 1/6/2026 to review policy on nursing home level of care residents. A plan to be agreed upon on 1/6/2026 with intention to discharge resident #3 by 1/31/2026 to ensure safe transition to a more appropriate level of care.	1/6/2026	Regular team meetings involving relevant parties, weekly, until resident #3 is placed and then discharged.	Program Nurse, Program Manager R463 accepted by LTCM 12-30-25