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

January 12, 2026

Wendy Beatty, Manager
Equinox Terrace
324 Equinox Terrace Road
Manchester Center, VT 05255-9253

Dear Ms. Beatty:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 9, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0127	A. BUILDING: _____ B. WING _____	12/09/2025

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EQUINOX TERRACE	324 EQUINOX TERRACE ROAD MANCHESTER CENTER, VT 05255

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R100	Initial Comments On 12/9/25 he Division of Licensing and Protection conducted an unannounced on-site annual survey. The following deficiencies were identified:	R100	This plan of correction was written to follow state and federal guidelines. It is not an admission of noncompliance. However, it is the homes commitment to demonstrate and maintain compliance.	
R113 SS=F	5.2.c (7) Uniform Consumer Disclosure- Admit Agreements In addition to general resident agreement requirements, agreements for all ACCS participants must include: A home certified to provide assistive community care services (ACCS) must designate a staff person responsible for case management. Residents must be informed upon admission, and any time there is a change, of the name of the staff person responsible for case management. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to designate a Case Manager for residents of the home receiving Assistive Community Care Services (ACCS). Policies and procedures related to Assistive Community Care Services including designation of a staff member to provide Case Manager for residents receiving ACCS have not been developed by the home. Per the Executive Director and the Health Services Director during an interview commencing at 11:42 AM, and per record review, the home cares for residents who receive ACCS. At 11:45 AM on 12/9/25 the Executive Director	R113		

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R113	Continued From page 1 confirmed a staff member has not been delegated to provide case management for the residents of the home receiving ACCS.	R113	R113 The Medicaid Policy and the ERC/ACCS residency agreement have been updated with the designation of the Executive Director as case manager. All residents who participate with ERC/ACCS have the potential to be effected by this alleged deficient practice. A copy of the Medicaid policy with designation of the case manager has been posted in a public area for access by all. Admission agreement audits will occur to ensure compliance. Results will be reported and discussed in QAPI. Responsible: ED Date of Compliance 1/9/26 R113 Plan of Correction accepted by Jo A Evans RN on 1/11/26.	
R161 SS=F	5.9.c (4) Nursing Services For each resident requiring nursing overview, administration of medication, or nursing care, the registered nurse must: Provide instruction and oversight to all direct care personnel regarding each resident's health care needs and nutritional needs. Delegate nursing tasks as appropriate, following the Board of Nursing's recommended practices, with adequate documentation of delegation; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure the Registered Nurse responsible for nursing oversight at the home instructs and delegates direct care staff to perform the nursing tasks required to meet resident needs. Finding include: During an interview conducted at 10:55 AM on 12/9/25 a Med Tech confirmed they were instructed by Med Techs and a Licensed Practical Nurse during their training to perform nursing skills including preparation and administration of specific medications to designated residents, and provision of the care for the home's residents. The Med Tech confirmed that after receiving training to perform nursing tasks including practicing preparing and administering medications to residents with staff other than a Registered Nurse, they were delegated the	R161		

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R161	Continued From page 2 responsibility to perform these nursing skills by the Health Services Director (HSD). Per staff interview and record review, the home's Health Services Director is a Licensed Practical Nurse. Per review, a document entitled Welcome to our Company is provided to newly hired staff and states on the day of hire new staff can expect to meet their trainer. This handout includes a Sample List of Training Tasks including, but not limited to, the following nursing tasks: a. performing and assisting residents with activities of daily living b. performing nail care c. "Understanding the Diabetic & their Care" d. storing and administering Oxygen e. performing passive range of motion exercises and "Understanding exercises & showing resident" f. performing transfers from wheelchair to bed g. turning and repositioning in bed h. use of equipment for transfers including a gait belt and a Hoyer Lift i. observing and reporting pain j. measuring and recording intake and output k. collection of urine specimens and preparation of bowel specimens This document also includes a form for documenting competency in the skills identified on the Sample List of Training Tasks which includes columns for the employee's initials and their supervisor's initials. This form does not include a designated area for the Registered Nurse's signature. On the afternoon of 12/9/25, the Executive Director and Health Services Director confirmed during the home's orientation process staff are trained to perform nursing tasks by staff other	R161	R161 Staff will be trained to perform nursing tasks by an RN. The orientation skills checklist will include a designated sign off by the RN. All residents residing at Equinox Terrace have the potential to be effected by this alleged deficient practice. Nurse management staff have been educated on the requirement that staff be trained on preparation and administration of medications by an RN. Audits of med tech training checklists will be conducted weekly x4 then monthly x3 to ensure compliance. Results will be reported and discussed in QAPI. Responsible: RN, HSD Date of compliance 1/9/2026	

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R161	Continued From page 3 than a Registered Nurse.	R161	R161 Plan of Correction accepted by Jo A Evans RN on 1/11/26.	
R203 SS=F	5.10.h (1) Medication Management All drugs, medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication must be used only for the resident identified on the pharmacy label. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel must have access to the keys. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure medications managed by the home are stored in a locked compartment to prevent resident access. Findings include: Policies and procedures governing secure storage of medications in a locked compartment were not provided for review on request. During the tour of the home commencing a approximately 9:40 AM on 12/9/25 unsecured medications were observed in Resident Room #30 to include 3 bottles of Nystatin Powder, A bottle of Tums, and a container of Benefiber. This finding was confirmed by the Executive Director at 11:42 AM on 12/9/25.	R203	R203 Unsecured medications were removed from room # 30. All residents who take medications have the potential to be effected by this alleged deficient practice. Staff have been educated on removing any medications that are found in the resident rooms. Audits of resident rooms for medications will be conducted weekly X4 and then monthly X3 to ensure compliance. Results will be reported and discussed at QAPI. Responsible: HSD and ED Date of compliance 1/9/26	
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	R210	R203 Plan of Correction accepted by Jo A Evans RN on 1/11/26.	

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R210	Continued From page 4 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; (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 staff training is completed as required. Findings include: The home's Staff Development and Training	R210	R210 No residents were effected by this alleged deficient practice. Staff have received 8 hours of dementia training. Management staff have been educated on the requirement of 8 hours dementia training on hire and 2 hours annually. Audits of new hire education will conducted weekly x 4 then monthly x 3 in order to ensure compliance. Results will be reported and discussed at QAPI. Responsible: HSD and ED Date of compliance: 1/9/26 R210 Plan of Correction accepted by Jo A Evans RN on 1/11/26.	

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R210	Continued From page 5 policy and procedures effective as of September 2025 states, "Staff will receive a general orientation and at least twelve (12) hours of trainings upon hire and each year. Staff will complete their (12) hours of training before they can start on the floor." At 1:05 PM the Executive Director was requested to provide documentation of trainings completed by 5 sampled staff. Per review of the documentation provided for review, 3 out of 5 staff did not complete the required 2 hours of yearly dementia training and 1 applicable staff out of the sample of 5 staff did not complete 8 hours of Dementia training on hire and before providing care to residents as required. Per the list of all staff and the 2025 In-Service training records provided by the Executive Director for review, the home has hired 10 direct care staff hired since 4/1/25. Per an expanded sample of all staff hired following the implementation of the Residential Care Home and Assisted Living Residence Licensing Rules effective 4/1/2025, all 10 direct care staff listed as hired after 4/1/25 did not complete the required 8 hours of dementia training. Additionally, per the 2025 In-Service training records provided for review, 10 out of 10 direct care staff hired after 4/1/25 did not complete 12 hours of training prior to providing care to residents of the home as required. At 3:17 PM the Executive Director stated they were not aware of the requirement to provide 8 hours of dementia training on hire and confirmed all staff are cross-trained to work in the home's memory care center. At this time, the Executive also confirmed 4 out of 5 sampled staff had not completed required for dementia trainings, and	R210		

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R210	Continued From page 6 the training requirements for all applicable staff upon hire was not completed in accordance with the licensing rules effective 4/1/25.	R210		
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 ensure care in a safe environment. Findings include: Policies and procedures governing maintenance of a safe environment and secure storage of cleaning chemicals and other hazardous compounds were not provided for review on request. During a tour of the home commencing at approximately 9:40 AM on 12/9/25 the following safety concerns were observed in the resident living environment: 1, The Salon was unlocked and unattended. Multiple hazardous items including barbicide; isopropyl alcohol; nail polish, nail polish remover and nail polish drying spray, and other toxic nail care products; numerous health and beauty products containing toxic substances; disinfectant wipes and cleaning chemicals accessible to residents of the home were observed in this resident accessible area of the home.	R401		

R401

No residents were effected by this alleged deficient practice.

A combination lock was installed on the salon door.

Resident room #33 bed rail was secured adequately.

Oxygen sign was placed on the entrance of room #28.

Comet and plant food were removed from room #33.

Veneer has been replaced on Memory care medication cart.

"Silent night" pill crusher was cleaned.

Staff will be trained on observing rooms for chemicals, oxygen signs when warranted, secured side rails and unclean "silent night" pill crusher.

Audits of resident rooms for chemicals and proper signage, bed rails and pill crushers will be conducted weekly x 4 then monthly x 3 to ensure compliance. Results will be reported and discussed at QAPI.

Responsible: HSD and ED

Date of compliance: 1/9/26

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R401	Continued From page 7 2. Resident Room #17 was observed with a side rail which was not adequately secured to the bed or positioned securely against the mattress to mitigate the risk for entrapment and injury. 3. Resident Room #28 was observed with oxygen tanks stored and in use in the room. A sign indicating oxygen was in use in this room was not posted at the entrance to this room. 4. Resident Room #33 was observed with a container of Comet disinfecting powder and a container of liquid all purpose plant food unsecured and accessible to residents of the home. 5. The layer of veneer on the top of the medication cart in the Memory Care Center was observed to be damaged with the plastic peeling away leaving sharp edges exposed and areas of the cart which can not be cleaned exposed. These findings were confirmed by the Executive Director a 11:42 AM on 12/9/25. 6. The "Silent Knight" pill crushing device used in the memory care center was observed to be unclean and poorly maintained with stains on top of this device and white powder which appeared to be residue from pills crushed in the device was observed to have accumulated in the base at the back of this device. These findings were confirmed by the Health Services Director at 1:07 PM on 12/9/25.	R401	R401 Plan of Correction accepted by Jo A Evans RN on 1/11/26.	